Health and welfare services in Canada
1966

HEALTH AND WELFARE SERVICES IN CANADA

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by the

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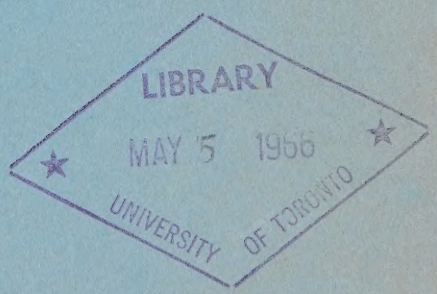

Ottawa, December 1965

This booklet deals only with programs on which the Research and Statistics Division reports for the Canada Year Book. Information on the National Employment Service, Unemployment Insurance, and programs for War Veterans and other data prepared by other agencies are therefore not included.

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HEALTH AND WELFARE SERVICES

IN CANADA

INTRODUCTION

Canada's growth as an industrial nation has created many new problems in the planning of health and welfare services. While a higher level of income and living standards lessens the danger of health impoverishment, changing social conditions resulting from general prosperity are forcing the consideration of new priorities in health and welfare planning. With the continued influx of people to the cities, problems of adequate housing, recreation, health and welfare services for the aged, and other aspects of community planning, require more urgent consideration. At the same time, problems associated with the rendering of services to a proportionately decreasing rural population and to the sparsely settled northern expanses severely tax the available resources of health and welfare personnel and public health and public welfare administration.

During 1964-65 the Royal Commission on Health Services published the results of its inquiry into the present status of health services in Canada. It declared that, for the nation to achieve its health goals, a universal, comprehensive, health services program should be available to all Canadians. The federal government, responding to this report, proposed in 1965 that a comprehensive medical care program be introduced. In opening a Federal-Provincial Conference in July 1965 the Prime Minister said that "Canadian attitudes and Canadian economic standards have now developed to the point at which we are ready to regard medicare as a part of Canada's basic social standards. It is now the responsibility of the federal government to co-operate with Provinces in making medicare financially possible for all Canadians." Earlier in the year British Columbia had passed the Medical Grant Act in March, and Ontario had passed the Medical Services Insurance Act in June; both these acts provided for provincial subsidies to assist residents whose taxable incomes were less than $1,000 a year in paying the premiums required to purchase medical care insurance from an approved medical insurance carrier.

In November 1964, the federal government introduced a Bill "to establish a comprehensive program of old age pensions and supplementary benefits in Canada payable to and in respect of contributors". After second reading this Bill was referred to a Special Joint Committee of the Senate and House of Commons set up to study it. The Committee held 51 sittings from November 24, 1964 to February 8, 1965 and heard 116 witnesses.

In its final report the Committee recommended a few changes in the Bill, most of which were accepted by the government. The House of Commons debated the Bill from February 22 to March 29, and the Canada Pension Plan received Royal Assent on April 3, 1965. Before the Bill was introduced, a series of meetings had been held between federal and Quebec officials from May to October 1964 in order to integrate the details of the Canada Pension Plan and the Quebec Pension Plan. The Quebec Pension Plan was assented to and became effective on July 15, 1965. The revised Ontario Pension Benefits Act, which regulates the operations of private pension plans in the province, was proclaimed on July 30, 1965.

With the April 1965 Throne Speech, Canada embarked on its own "War on Poverty", its program for the full utilization of human resources and the elimination of poverty. Included in the program will be an expansion of the area development program (ADA) and the agricultural rehabilitation and development program (ARDA), measures to assist the re-employment, relocation and retraining of workers, urban renewal measures, the establishment of a Company of Young Canadians to undertake projects for economic and social development in Canada and abroad, and the establishment of a Canada Assistance Plan. This last will be a companion to the Canada Pension Plan, designed to assist people now retired, disabled, widowed, or otherwise in need who will not be able to participate in the contributory pension plan. Provincial programs for persons in need will be financially supported by federal cost-sharing arrangements.

During the year public and voluntary agencies and interested individuals have been actively engaged in the preliminary work for the Canadian Conference on Aging, sponsored by the Canadian Welfare Council, to be held in January 1966 in Toronto. The Special Committee of the Senate on Aging, formed in 1963 to study various aspects of the needs of older people, including their housing, health and institutional care, social services, community participation, and recreation, held hearings from February 1964 into December 1964. The report of the committee is in preparation.

Family welfare was the particular subject of the Canadian Conference on the Family, convened by Their Excellencies, Governor-General and Madame Vanier, and held in Ottawa in June 1964. The Conference recommended the formation of an Institute of the Family to stimulate and foster study of the family and to constitute a medium of continuous action in favour of the family, as well as a meeting-ground and channel of communication for groups and individuals actively concerned with the well-being of Canadian families. The Vanier Institute of the Family - L'Institut Vanier de la famille - was consequently established and incorporated on April 8, 1965.

PART I - PUBLIC HEALTH

Provincial governments bear the major responsibility for health services in Canada, with the municipality often assuming considerable authority over matters delegated to it by provincial legislation. The federal government has jurisdiction over a number of health matters of a national character and provides important financial assistance to provincial health and hospital services. All levels of government are aided and supported by a network of voluntary agencies working in different health fields.

Section 1 - Federal Health Activities

The Department of National Health and Welfare is the chief federal agency in health matters but important treatment programs are also administered by the Departments of Veterans Affairs and National Defence. The Dominion Bureau of Statistics is responsible for collection, analysis, and publication of national health statistics, the Medical Research Council and the Defence Research Board administer medical research programs, and the Department of Agriculture has certain health responsibilities connected with food production.

The Department of National Health and Welfare controls food and drugs, including narcotics, operates quarantine and immigration medical services, carries out international health obligations, and provides health services to Indians, Eskimos, and other special groups. It advises on the visual eligibility of applicants for blindness allowances and co-operates with the provinces in the provision of surgical or remedial treatment for recipients of the allowances. Under the Public Works Health Act, supervision of health conditions is provided for persons employed on federal public works. Health counselling and medical supervision are provided for the federal Civil Service. The Department also administers the civil aviation medical program for the Department of Transport.

The Department serves the provinces in an advisory and co-ordinating capacity and administers grants to provincial health and national voluntary agencies. Administration of federal aspects of the Hospital Insurance and National Health Grant Programs has become a major activity during the past decade.

Subsection 1 - The Royal Commission on Health Services

Focusing on the theme that "all the fruits of the health sciences" should be made "available to all our residents without hindrance", the Royal Commission on Health Services, chaired by Chief Justice Emmett M. Hall of Regina and also including a nurse, a dentist, an economist, a financier, and two physicians, brought out its two-volume report(1) in 1964 and 1965, setting out its findings and its recommendations. It conducted public hearings in every province, received 406 briefs, and commissioned a number of special studies.

The terms of reference of the Hall Commission, as it became known, were to inquire into and report upon: methods for providing health services, and their correlation and improvement; personnel and training; physical plant; costs, and methods of financing; medical research; priorities; and "such other matters as the Commissioners deem appropriate".

As the Commission pursued its inquiries it particularly noted in the health field what it called "the paradox of our age", and defined as "the enormous gap between our scientific knowledge and skills. . . and our organizational and financial arrangements to apply them". It recommended that "this gap be closed". Its central recommendation was "That the Federal Government enter into agreements with the provinces to provide grants on a fiscal need formula to assist the provinces to introduce and operate comprehensive, universal, provincial programmes of personal health services, with similar arrangements for the Yukon and the Northwest Territories." The plans would cover medical services, prescription drug services, prosthetic services, home care services, optical and dental services for recipients of public assistance and for children, dental services for expectant mothers, and organized care of crippled and retarded children.

The Commission was of the opinion that the cost of the health care program that it had envisaged could be easily afforded by Canada. It anticipated a quadrupling of the gross national product between 1961 and 1991, and felt that the share of this devoted to health would "not encroach upon a greater share of Gross National Expenditure than it did in 1961 within a range of 1 to 1.5 percentage points".

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(1) Royal Commission on Health Services Volume I 1964, and ... Volume II 1965, Ottawa, Queen's Printer, 1964 and 1965.

It recommended that mental health services be completely reorganized and reoriented so as to end "all discrimination in the distinction between mental and physical illness", a discrimination it condemned as "unworthy and unscientific".

A Health Facilities Development Fund should be set up to expand the physical plant of Canada's health industry, Professional Training Grants should be offered to increase the trained personnel available, and a Health Professions University Grant should be established to extend the training facilities in Canadian universities.

In all, the Commission submitted 256 detailed recommendations. Some of the topics covered by these were: health care programs, mental health, alcoholism, drug addiction, dental care, prescription drugs, optical services, hospital care, prosthetic services, home care services, nursing education, medical education, dental education, the education of dental auxiliaries, health research, health statistics, health financing, National Health Grants, priorities in health care, pharmacists, paramedical personnel, radiography, and northern health services.

Subsection 2 - Food and Drug Control

The Food and Drugs Act is a federal statute with provisions applying to the manufacture, advertising, packaging, and sale of foods, drugs, cosmetics, and medical devices anywhere in Canada. Wide powers are authorized under this legislation to maintain the safety, purity, and quality of food and drug products and to prevent misrepresentation in labelling and advertising. There are prohibitions, for example, on the sale of food or drugs that do not meet prescribed standards, are harmful, adulterated, dirty, improperly stored, or manufactured under unsanitary conditions. The Act also prohibits the advertising of any food, drug, cosmetic, or medical device as a preventive or cure for a number of serious diseases and also lists drugs that may be sold only by prescription.

Standards of safety and purity are maintained through constant and widespread inspection and laboratory research. The inspection of food-manufacturing establishments plays a major role in the production of clean, wholesome foods containing ingredients that meet recognized standards. Changing food technology requires the development of methods of laboratory analysis to assure the safety of new types of ingredients and packaging materials. The Food and Drug Regulations were amended in 1964 by the addition of sections listing chemical additives that may be used in foods, the

amounts that may be added to each food, and the underlying reason. The effect of new packaging and processing techniques on the bacteria associated with food spoilage is another matter of special concern. Since the Food and Drugs Act is intended for the protection of consumers, a section of the Food and Drug Directorate obtains consumer opinions, deals with individual consumer complaints, and provides sound information on which consumers can base opinions.

Drug standards are subject to continuous review and testing. Detailed information on all new drugs must be reviewed by the Directorate to determine compliance with requirements before release for sale is permitted. In 1963 important regulations were issued, one setting standards operative in all drug manufacturing facilities and the second prescribing additional safeguards in the distribution of investigational drugs. Drug manufacturing requirements relate to sanitation of facilities, employment of qualified personnel, testing to ensure standards of quality and safety at stated stages of processing, maintenance of records of testing performance, together with a system of control to enable a complete and rapid recall of any lot or batch of drugs from the market. The new controls over clinical trials and marketing of new drugs carry out provisions of the Food and Drug Act amendment passed in 1962. Detailed information must be submitted to the Directorate concerning the method of manufacture, the tests applied to establish standards of safety and quality, and substantial evidence of the clinical effectiveness of the new drug for the purposes stated. Samples of the final product must also be submitted. Before putting a product into clinical testing a manufacturer also must file complete data on the experience with the drug including any evidence of adverse side effects, and the qualifications of the persons to be engaged in its experimental use. If from this evidence a new drug is considered not in the interest of public health the Minister may suspend the proposed clinical testing. In the case of suspension of the clinical trials, the manufacturer has the right to appeal the decision. Drugs expressly prohibited from sale are thalidomide and lysergic acid diethylamide except under certain conditions, as specified in the regulations, whereby sale by a manufacturer to an institution for clinical use or laboratory research by qualified investigators may be approved by the Minister. Any drug that can be classed as a sedative, hypnotic, or tranquillizer is listed to be sold only on prescription. The licensing of persons dealing in certain drugs classed as barbiturates and amphetamines is required as well as the keeping of special records and the limitation of their use to medical purposes.

The Food and Drug Directorate also administers the Proprietary or Patent Medicine Act, which is concerned with the registration before marketing and the annual licensing of secret-formula medicines sold under proprietary or trade names.

Early in 1965 the Directorate initiated an adverse-drug-reaction reporting program in 16 teaching hospitals across Canada to recognize and investigate unexpected reactions to drugs. The co-operation of the medical, dental, veterinary, and pharmaceutical professions was solicited in advising the Directorate of such reactions in private practice. Close liaison is maintained with the World Health Organization and other authorities in foreign countries for the prompt reporting of such reactions.

Regulation of the supply and use of narcotic drugs is carried out under the Narcotic Control Act, as revised in 1961. This legislation prescribes a maximum penalty of seven years with no minimum for illegal possession; a maximum penalty for trafficking of life imprisonment; and minimum and maximum penalties for illegal export and import of seven years and life imprisonment, respectively.

Subsection 3 - Medical Services

The Department of National Health and Welfare provides several types of direct medical service through the Directorate of Medical Services, described in the following paragraphs.

Indians and Eskimos. - Responsibility for the general welfare, education, and medical care of Indians is shared with the Indian Affairs Branch of the Department of Citizenship and Immigration, and, of Eskimos, with the Department of Northern Affairs and National Resources. The Department of National Health and Welfare provides medical and public health services to registered Indians or Eskimos who are not included under provincial arrangements and who are unable to provide for themselves. A large volume of the service in treatment and health education is rendered to patients through departmental clinics of the out-patient type, which are staffed by medical and other public health personnel. In remote areas, the key facility is frequently the departmental nursing station, a combined emergency treatment and public health unit having two to four beds under the direction of one or two nurses; about 44 of these are operated throughout Canada.

Wherever practicable, there has been an increasing integration of Indians into provincial and municipal health agencies. As arrangements develop in the provinces for integrating Indians under the provincial services, the Department correspondingly reduces the number of hospitals and other facilities provided specifically for Indians. At present the Department maintains 18 hospitals at strategic points and co-operates elsewhere with community, mission, or company hospitals. Indians are now included under all provincial prepaid insurance plans for hospital care and other forms of insured medical care but in almost all cases the cost of mental and tuberculosis care is directly borne by the federal government. Indian and Eskimo health workers are trained to give instruction in health care and sanitation.

Northern health.- Because of the special problems in developing health services in the Far North, the Directorate of Medical Services has been given the responsibility of co-ordinating federal and territorial health care for all residents. In so doing, the Department undertakes the functions of a health department for the Council of the Northwest Territories and assists the territorial government of the Yukon Territory to provide certain health services. A close liaison is maintained with the federal departments directly responsible for administrative matters affecting these areas.

In the Yukon Territory, services for the total population administered through the Commissioner for the Yukon and provided on a cost-sharing basis with the Department of National Health and Welfare include complete treatment for tuberculosis, payment for services rendered at the Alberta cancer clinics, mental hospital care through arrangements with the Province of British Columbia, and medical care for indigent patients. Public health nursing services, measures for control of communicable diseases, and administration of the principal public hospital are primarily the responsibility of the Medical Services of the Department of National Health and Welfare.

In the Northwest Territories similar services are provided, the costs being shared by the Department of Northern Affairs and National Resources and the Department of National Health and Welfare. Indigent residents are eligible for medical, dental, and optical services as well as for tuberculosis and mental care.

Sick mariners. - The Department of National Health and Welfare provides compulsory prepaid medical, surgical, hospital, and other treatment services to crew members of all foreign-going ships arriving in Canada and Canadian coastal vessels

in interprovincial trade, and provides medical, surgical, and treatment services on an elective basis to crew members of Canadian fishing and government vessels. (Canadian seamen obtain their hospital care under the provincial hospital insurance plans.)

Leprosy. - Since 1960, isolation and treatment of persons suffering from leprosy have been arranged in their home neighborhoods. Under the provisions of the Leprosy Act, facilities for the diagnosis and treatment of leprosy are provided in a six-bed unit of the Hôtel-Dieu Hospital at Tracadie, New Brunswick.

Quarantine. - Under the Quarantine Act all vessels, aircraft, and other conveyances and their crew and passengers arriving in Canada from foreign countries are inspected by the quarantine officers to detect and correct conditions that could lead to the entry into Canada of such diseases as smallpox, cholera, plague, yellow fever, typhus, and relapsing fever. Fully organized quarantine stations are located at all major seaports and airports.

Immigration. - Under the Immigration Act and the Department of National Health and Welfare Act, the Immigration Medical Service conducts in Canada and other countries the medical examination of all applicants for immigration to Canada and also provides treatment for certain classes of persons after arrival in Canada, including immigrants who become ill en route to their destination or while awaiting employment.

Civil service health counselling. - Formerly available chiefly to the public service in Ottawa, health counselling is now offered through major medical services units to federal employees throughout the country. This service is primarily diagnostic and advisory only, but emergency treatment can also be given if required. The Civil Service Health Counselling Division has also the responsibility of examining civilian aviation personnel and providing advice on standards of physical fitness required for them.

Aerospace medicine. - Research on civil aerospace medicine is conducted by the Department in close liaison with the National Research Council, the Defence Research Board, and the Royal Canadian Air Force Institute of Aviation Medicine.

Regulation of hygienic standards. - The Department of National Health and Welfare is responsible for regulating hygienic standards on federal property.

Subsection 4 - Health Research

Health research in Canada is carried on in universities, hospitals, research institutions, and government departments. The main sources of financial support are governments, voluntary agencies, charitable foundations, professional bodies, and business corporations.

The federal government conducts medical and dental research itself (intramural research) in the Department of National Health and Welfare and the Defence Research Board. The Medical Research Council, the National Research Council, the Department of National Health and Welfare, the Department of National Defence, the Department of Veterans Affairs, and the Queen Elizabeth II Fund all give financial support to research in universities, hospitals, and other institutions (extramural research).

The Medical Research Council, formed in 1960 from the National Research Council's former Division of Medical Research, is the principal federal health-research advisory and co-ordinating agency. Its primary concern is the support of fundamental research in the basic medical sciences. It administers most of the federal medical research grants that support full-time investigation by research scientists in Canadian medical schools and their affiliated hospitals.

The National Research Council pursues in its broad program many investigations relevant to health. Its Associate Committee on Dental Research administers specific grants for dental research and training dental-research personnel.

The Department of National Health and Welfare supports both extramural and intramural health research, chiefly of an applied nature. Intramural research is carried on by the Food and Drug Directorate, the Laboratory of Hygiene, the Occupational Health Division, the Nutrition Division, the Radiation Protection Division, the Epidemiology Division, the Dental Health Division, and the Research and Statistics Division. The Department's extramural research program is composed of surveys and investigations that have the prior approval of the provinces for assistance under the National Health Grants Program. Assisted projects are either of a general public health nature or of specific application to such an area as mental health, child and maternal health, cancer, tuberculosis, rehabilitation, public-health administration, hospital administration, sanitation, or epidemiology.

The Defence Research Board sponsors both intramural and extramural research on medical problems of defence interest. Units have been established in four universities to conduct research in Arctic medicine, radiobiology, psychiatry, and aviation medicine.

The Department of Veterans Affairs maintains a program of medical research in its hospitals and clinics across Canada, mainly dealing with conditions affecting aging, such as arthritis and arteriosclerosis, which the Department is particularly able to investigate.

The Queen Elizabeth II Fund for Research in the Diseases of Children, established by the federal government in 1959, makes a fixed annual sum available for training researchers and scientists in childrens' diseases.

Subsection 5 - Radiation Protection

A comprehensive radiation protection program has been developed in Canada in response to the rapidly increasing use of radioactive materials, X-ray equipment, and nuclear reactors in medicine, industry, and research, and to increasing concern about radiation from atmospheric testing of nuclear weapons, from medical X-ray procedures, and from natural sources.

Because of the technical complexity of this new field and the necessity of imposing national controls over uranium and its by-products, the federal government has developed procedures for the safe handling and use of all radioactive materials. These procedures are implemented through the close collaboration of federal and provincial health departments, supported by special advisory committees.

Acting under the federal Atomic Energy Control Regulations, the Department of National Health and Welfare reviews all applications for radioisotope licenses and recommends health and safety conditions. The Department also provides services for measuring and recording the personal radiation exposures of workers handling X-ray, gamma-ray, and neutron sources. Licensed establishments are inspected by federal or provincial officers.

Although there is no federal regulatory authority to provide health and safety supervision over the use of X-rays, the Department of National Health and Welfare has taken an

active interest in this field. It has established a committee on the development of X-ray safety standards to recommend uniform standards and procedures throughout Canada. Five provinces (Nova Scotia, Quebec, Ontario, Saskatchewan, and Alberta) have already enacted specific enabling legislation applicable to X-rays, and two (Nova Scotia and Saskatchewan) have issued regulations requiring registration of operators and/or equipment. The Department of National Health and Welfare makes its personnel-radiation-monitoring service available to X-ray workers and provides copies of its reports to the appropriate provincial department of health.

As a supplement to its monitoring and inspection activities, the Department of National Health and Welfare provides short-term training courses in radiation protection for those persons assigned local responsibility for day-to-day operations.

Special attention is given to the health and safety problems associated with the siting, design, construction, and operation of nuclear reactors and charged-particle accelerators. Committees of the Atomic Energy Control Board, including federal and provincial representatives, review these matters.

A comprehensive nation-wide monitoring program has been developed to assess the exposure of the public to radiation from radioactive fallout from nuclear-weapons testing. The Department is assisted in the systematic collection of samples of air, precipitation, soil, wheat, milk, and human bone by the Departments of Transport and Agriculture and pathologists in hospitals throughout Canada. Reports of the concentration of such fallout components as strontium-90 and cesium-137 in these samples are published monthly. Because of a unique food-chain cycle in the Far North, a special study of cesium-137 in the North has been added to the nation-wide program. Direct measurements of cesium-137 levels in living persons are made with a high-sensitivity detection system known as a "whole-body counter". This system is also used in the follow-up of radiation workers whose bodies may have been exposed to internal contamination from leaky radioactive sources or as a result of an accident.

The Department of National Health and Welfare and the Ontario Department of Health also conduct a joint environmental monitoring program around nuclear reactor sites to ensure that the operation of the reactor does not result in the gradual build-up of radioactive contamination to levels of significance to the health of the people in that community.

Section 2 - Federal-Provincial Health Activities

The Department of National Health and Welfare serves the provinces in an advisory and co-ordinating capacity and administers grants to provincial and voluntary health agencies. Administration of federal aspects of the Hospital Insurance and National Health Grant programs has become a major activity during the past decade. Co-ordination with the provinces on health matters is facilitated by the Dominion Council of Health.

Subsection 1 - Medicare

Proposals for a plan of comprehensive medical insurance for all Canadians, administered by the provinces and with federal fiscal contributions, were made by the Prime Minister at the Federal-Provincial Conference in July 1965. The federal contributions would be dependent upon the fulfilment of four criteria by each provincial plan. The first is that it should cover, as a minimum, "all the services provided by physicians, both general practitioners and specialists", except for services available under other legislation and certain limited types of services, such as cosmetic surgery that is not medically necessary. The second criterion is that it cover all residents, or at least "be aimed at universal coverage", without exclusion because of age, economic circumstances, or pre-existing conditions. The third criterion is that it be "publicly administered, either directly by the provincial government or by a provincial government agency". The fourth is that benefits be fully transferable from one province to another. The amount of the federal contribution would be "half the national per capita cost of medical care programs based on the best available estimates at the time of their introduction", with retroactive adjustments if necessary; the contribution would be the same per capita amount for each province.

Supplementing this program, the Prime Minister also proposed to set up a Health Resources Fund that would "support the construction and equipment of facilities for health research and training". On September 23, 1965 he announced that the amount of the proposed fund would be $500 million over a 15-year period commencing in 1966. He said, "The basic purpose of the Fund is to help meet the greater need for trained people to provide medicare services. Through the Fund, federal capital grants will be available for the construction, renovation and basic equipment of research establishments, teaching hospitals, medical schools and training facilities for other health personnel. Grants from the Fund will not be available to meet the operating costs of such establishments."

Subsection 2 - National Health Grant Program

The National Health Grant program, inaugurated in 1948, makes federal grants available to the provinces for the developing and strengthening of public health and hospital services. Originally there were nine continuing grants: the Hospital Construction, Professional Training, General Public Health, Public Health Research, Mental Health, Tuberculosis Control, Cancer Control, Venereal Disease Control, and Crippled Children Grants. One other, the Health Survey Grant, lapsed in 1953 after the completion of provincial health surveys. In 1953 three new grants were established: Child and Maternal Health, Medical Rehabilitation, and Laboratory and Radiological Services.

In 1958, federal assistance under the Hospital Construction Grant was increased to $2,000 per hospital bed (whether active treatment, chronic, mental, or tuberculosis), double the previous grant for active treatment beds. In addition, funds were made available to meet up to one-third of the cost of approved alterations and renovations to existing facilities, with the federal contributions being at least matched by the provinces.

Beginning with the fiscal year 1960-61, a redistribution and merging of certain grants was effected to provide a more flexible measure of assistance and at the same time make larger amounts available for programs where additional aid was necessary. Adjustments were also required for services aided under certain grants, such as laboratory and radiological services and cancer control, now aided under the Hospital Insurance program. The total allocation remained approximately the same but the number of separate grants was reduced to nine. The General Public Health Grant was increased by almost $5,500,000 and projects under two previously separate grants -- the Laboratory and Radiological Services Grant and the Venereal Disease Control Grant -- were absorbed into it. The Medical Rehabilitation and Crippled Children Grants were merged and their combined allocation increased by more than $1,000,000. The Mental Health Grant was increased by more than $1,500,000 and the Professional Training and the Public Health Research Grants by about $1,250,000 each. The Tuberculosis Control Grant was decreased by nearly $750,000 and the Child and Maternal Health and Cancer Control by lesser amounts. The grants for professional training and public health research, previously fixed amounts, were placed on a per capita basis, to increase with expansion of the population.

In 1962-63 flexibility was increased by setting aside an amount of $250,000 in the Medical Rehabilitation Grant to be distributed not on a per capita basis but to be granted to the provinces for use in special projects to assist children with congenital defects. Part of the Cancer Grant - $350,000 - was also allocated for cancer research to be distributed upon application.

During the fiscal year 1964-65 the following Health Grants were in force: Hospital Construction, Mental Health, Tuberculosis Control, Cancer, Medical Rehabilitation and Crippled Children, Professional Training, Public Health Research, Child and Maternal Health, and General Public Health.

Up to March 31, 1965, aid for hospital construction had been approved for 117,015 beds and 14,901 bassinets for patients, 22,555 beds for nurses, and 918 beds for interns. Approximately 42,000 health workers had been trained or were undergoing special training, and more than 7,000 health workers were employed, with Health Grant assistance. The amount expended in 1964-65 totalled $56,699,708 or 86 per cent (Table 1) of the amount available; over the entire seventeen years of the programs, 79 per cent of the available moneys had been actually spent.

Subsection 3 - Hospital Insurance

The federal-provincial hospital insurance program, now established in all provinces and territories, covers 98.4 per cent of the total population of Canada. This program was introduced under the federal Hospital Insurance and Diagnostic Services Act of 1957, by which the federal government shares with the provinces the costs of specified hospital services to insured patients. The choice of methods of financing and administering the program at the provincial level, and the choice of the types of service offered above the minimum stipulated in the Act, rest with the provinces.

Federal legislation covers only services in institutions approved to provide acute, chronic, and convalescent care. Tuberculosis and mental hospitals are excluded from the federal-provincial plan, as are institutions providing custodial care. However, the psychiatric and tuberculosis units of general hospitals are included.

The basic range of in-patient benefits that, under the Act, each province is required to provide includes standard ward accommodation and meals, nursing service, drugs and biologicals, surgical supplies, the use of operating and case

TABLE 1 - AMOUNTS AVAILABLE AND PERCENTAGES EXPENDED UNDER THE NATIONAL HEALTH GRANT PROGRAM, BY GRANT, FOR THE SEVENTEEN-YEAR PERIOD ENDED MARCH 31, 1965, AND FOR THE YEAR ENDED MARCH 31, 1965

	1948-1965 period			Year ended March 31, 1965		
	Amount available(1)	Amount expended	Percentage expended	Amount available	Amount expended	Percentage expended
Crippled Children(2)	6,207,728	4,431,677	71	-	-	-
Professional Training	15,554,573	14,364,320	92	2,176,229	1,933,446	89
Hospital Construction	238,678,896	216,323,305	91	26,994,404	21,512,346	80
Venereal Disease Control(3)	5,968,336	5,146,209	86	-	-	-
Mental Health	118,532,369	98,592,944	83	9,219,922	8,667,072	94
Tuberculosis Control	66,159,029	61,260,592	93	3,614,167	3,392,810	94
Public Health Research	14,216,048	12,071,895	85	1,889,600	1,647,674	87
Health Survey(4)	645,180	540,960	84	-	-	-
General Public Health	156,609,269	110,957,758	71	14,453,468	12,781,245	88
Cancer	60,335,567	43,824,956	73	3,269,914	2,890,943	88
Lab. & X-Ray Services(5)	47,404,300	14,450,881	30	-	-	-
Medical Rehabilitation(6)	6,500,000	3,016,750	46	-	-	-
Child and Maternal Health(7)	20,202,394	14,156,269	70	1,702,394	1,409,162	83
Medical Rehab. & Crippled Children	13,610,695(8)	8,673,078(8)	64(8)	2,910,695	2,465,006	85
Total	770,624,386	607,811,598	79	66,230,795	56,699,708	86

(1) As set out in the General Health Grant Rules.
(2) Merged with Medical Rehabilitation Grant, April 1, 1960.
(3) Absorbed into General Public Health Grant, April 1, 1960.
(4) Lapsed in 1953 following the completion of provincial health surveys.
(5) Introduced in 1953 and absorbed into General Public Health Grant, April 1, 1960.
(6) Introduced in 1953 and merged with Crippled Children Grant, April 1, 1960.
(7) Introduced in 1953.
(8) Amounts for 1960-65 only; see footnotes 2 and 6.

rooms, diagnostic procedures (including X-ray and laboratory procedures) together with necessary medical interpretations, and the use of radiotherapy and physiotherapy facilities where available. The same benefits for out-patients, although authorized for assistance under the federal legislation, are not mandatory upon provincial plans. All provinces but one provide under the plan some insured out-patient services. The pattern varies from province to province, but among the services offered are emergency care following accidents, diagnostic services, and therapeutic services, including minor surgical and medical procedures. Some provinces provide certain psychiatric out-patient services.

Provinces use different methods of administering and financing their programs, and establishing eligibility for benefits. In some provinces the hospital insurance program is administered by the Department of Health, in others by a separate hospital services commission. Moneys raised through general revenues, provincial sales taxes, and personal premiums are used separately and in combination, in different provinces. In the provinces where no premium system applies, residence in the province is the determining factor of eligibility for benefits; in the provinces with a premium system, eligibility for benefits is dependent upon payment of the premium as well as the fulfilment of the residence requirements. Coverage is universal in provinces where no premiums are levied, and it is either automatic or compulsory in all provinces except Ontario, where certain groups of people are free to join or not join the insurance program.

Under the cost-sharing formula specified in the Hospital Insurance and Diagnostic Services Act, the federal government pays each province 25 per cent of the per capita cost of in-patient services in Canada as a whole plus 25 per cent of the per capita cost of in-patient services in the province, multiplied by the average for the year of the number of insured persons in the province. On a national basis, the federal contribution amounts to about 50 per cent of sharable costs. However, for individual provinces the proportion of sharable costs met by the federal government varies, with a higher proportion of the cost of low-cost programs than of high-cost programs being met. Federal payments to the provinces under the program from July 1, 1958 to December 31, 1964, totalled over $1,700,000,000. During 1964, federal payments to the individual provinces and territories totalled $408,000,000, divided as follows: Newfoundland, $9,200,000; Prince Edward Island, $2,000,000; Nova Scotia, $15,500,000; New Brunswick, $13,000,000; Quebec, $117,200,000; Ontario, $144,500,000; Manitoba, $20,000,000; Saskatchewan, $22,200,000; Alberta, $29,600,000; British Columbia, $34,000,000; Yukon Territory, $330,000; and the Northwest Territories, $560,000.

Tables 2 and 3 deal with the data for hospitals listed in the federal-provincial hospital insurance agreements. The bulk of the hospitals listed in those agreements are "budget review" hospitals, which are subject to provincial budget-approval. Budget review hospitals include publicly owned general hospitals providing acute or short term care and special hospitals such as pediatric, maternity, orthopedic, and chronic hospitals. Also listed in the agreements are "contract" and federal hospitals. "Contract" hospitals include private and industrial hospitals that provide insured hospital care at a contractually-agreed rate per patient day. Federal hospitals include veterans' hospitals, Indian hospitals, and many small nursing stations operated by Indian and Northern Health Services.

As Table 2 shows, the end of 1963 there were 1,291 hospitals listed in the federal-provincial agreements, containing, as shown in Table 3, 129,158 hospital beds and cribs, a rate of 6.8 beds and cribs per thousand population. About 86 per cent of beds were in budget review hospitals, 5 per cent in contract hospitals, and 9 per cent in federal hospitals. Provincial rates of hospital beds per thousand population ranged from 5.0 per cent in Newfoundland to 8.6 in Alberta, and Territorial rates were even higher. In Quebec and in the Atlantic Provinces bed:population ratios were below the national average. In Ontario and British Columbia those ratios were close to the national average while in the remaining provinces they were above the national average (Table 3).

Table 4 shows that in 1963, patients spent a total of 37,667,120 days in hospitals listed in the federal-provincial agreements, of which 33,942,627 or 90.1 per cent were insured patient-days; there were 1,993.4 patient-days of adults and children per thousand of total population and 1,825.4 insured patient-days of adults and children per thousand of insured population. The number of insured patient-days per thousand of insured population varied from 1,229.6 in Newfoundland and 1,341.7 in British Columbia to 2,132.8 insured patient-days in Saskatchewan and 2,237.3 in Alberta.

Table 5 shows that the average length of stay of patients in the budget review general hospitals was 10.1 days and in the budget review chronic and convalescent hospitals the average length of stay per patient was 180.3 days. In the provinces the average length of stay in the budget review general hospitals ranged from 13.4 days in Newfoundland to 8.8 days in Manitoba. In the budget review chronic and convalescent hospitals the average length of stay ranged from 32.1 days in Nova Scotia to 380.4 days in Alberta. It should be mentioned that the chronic and convalescent length of stay data for patients in the budget review general hospitals that provide this type of care is not tabulated separately but is included in the rest of the length of stay data.

TABLE 2 - NUMBER OF HOSPITALS AND OTHER FACILITIES LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY STATUS OF HOSPITAL, BY PROVINCE, DECEMBER 31, 1963

Province	Number of hospitals				Number of other facilities(1)	Total number of hospitals and other facilities
	Budget review	Contract	Federal government	Total		
Newfoundland	39	5	1	45	1	46
Prince Edward Island	9	-	-	9	2	11
Nova Scotia	47	-	1	48	2	50
New Brunswick	38	-	2	40	1	41
Quebec	164	95	12	271	2	273
Ontario	215	92	11	318	4	322
Manitoba	79	8	17	104	2	106
Saskatchewan	152	4	3	159	11	170
Alberta	124	26	5	155	7	162
British Columbia	91	14	6	111	1	112
Yukon Territory	2	-	3	5	1	6
Northwest Territories	1	8	17	26	1	27
CANADA	961	252	78	1,291	35	1,326

(1) Includes 18 contract facilities (Red Cross blood depots) and 17 budget review facilities (provincial laboratories, cancer clinics, and restoration centres).

TABLE 3 - NUMBER OF BEDS AND CRIBS SET UP, AND RATE PER 1,000 POPULATION(1), IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY PROVINCE, AS AT DECEMBER 31, 1963

Province	Number of hospitals reporting	Beds and cribs set up	
		Number	Rate per 1,000 population
Newfoundland	45	2,403	5.0
Prince Edward Island	9	629	5.9
Nova Scotia	48	4,469	5.9
New Brunswick	40	4,008	6.5
Quebec	271	33,823	6.2
Ontario	318	44,965	7.0
Manitoba	104	6,951	7.3
Saskatchewan	159	7,769	8.3
Alberta	155	12,034	8.6
British Columbia	111	11,464	6.8
Yukon Territory	5	161	10.7
Northwest Territories	26	478	19.9
CANADA	1,291	129,154	6.8

(1) Based on 1963 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

TABLE 4 - TOTAL PATIENT-DAYS AND INSURED PATIENT-DAYS IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, WITH RATES PER 1,000 TOTAL AND INSURED POPULATION, ADULTS AND CHILDREN, BY PROVINCE, 1963

Province	Number of hospitals reporting	Total patient-days during year		Insured patient-days during year		Insured as a percentage of total patient-days
		Number	Rate(1)	Number	Rate(2)	
Newfoundland	46	640,835	1,332.3	588,959	1,229.6	91.9
Prince Edward Island	9	175,540	1,640.6	165,890	1,579.9	94.5
Nova Scotia	48	1,240,149	1,640.4	1,118,554	1,523.9	90.2
New Brunswick	40	1,173,702	1,911.6	1,031,860	1,702.7	87.9
Quebec	268	10,084,795	1,844.3	9,247,563	1,696.8	91.7
Ontario	322	13,467,462	2,088.6	12,099,892	1,927.2	89.8
Manitoba	104	1,970,147	2,073.8	1,750,677	1,914.9	88.9
Saskatchewan	159	2,046,236	2,193.2	1,951,013	2,132.8	95.3
Alberta	155	3,374,968	2,402.1	3,116,612	2,237.3	92.3
British Columbia	111	3,392,515	2,001.5	2,808,885	1,671.0	82.8
Yukon Territory	5	26,626	1,775.1	20,126	1,341.7	75.6
Northwest Territories	26	74,145	3,089.4	42,596	1,774.8	57.4
CANADA	1,296	37,667,120	1,993.4	33,942,627	1,825.4	90.1

(1) Per 1,000 total population; based on 1963 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

(2) Per 1,000 insured population; based on annual average number of insured persons under provincial plans, 1963.

TABLE 5 - AVERAGE LENGTH OF STAY(1) AND PERCENTAGE OCCUPANCY(2) IN BUDGET REVIEW GENERAL AND CHRONIC AND CONVALESCENT HOSPITALS, BY PROVINCE, 1963

Province	Budget review general hospitals				Budget review chronic and convalescent hospitals		
	Number of hospitals reporting		Average length of stay	Percentage occupancy	Number of hospitals reporting	Average length of stay	Percentage occupancy
	Average length of stay	Percentage occupancy					
Newfoundland	20	40	13.4	74.6	-	-	-
Prince Edward Island	8	8	9.9	76.0	-	-	-
Nova Scotia	44	44	10.3	75.7	1	32.1	87.9
New Brunswick	33	35	10.1	80.9	-	-	-
Quebec	129	130	10.3	81.3	25	190.9	92.5
Ontario	189	189	10.7	82.3	23	186.1	89.1
Manitoba	74	74	8.8	78.4	4	88.6	89.2
Saskatchewan	149	149	9.5	77.8	-	-	-
Alberta	105	105	9.0	74.1	18	380.4	89.8
British Columbia	86	86	9.5	82.2	-	-	-
Yukon Territory	2	2	7.7	39.2	-	-	-
Northwest Territories	1	1	8.5	61.7	-	-	-
CANADA	840	863	10.1	80.3	71	180.3	90.4

(1) Based on patient-days since admission of adults and children separated from hospital during year (discharges and deaths), divided by separations.

(2) Patient-days as a percentage of 365 times beds set up on December 31. Excludes bassinets and newborn-days.

The same Table 5 shows that the national average percentage occupancy for the budget review general hospitals, in 1963, was 80.3 and the corresponding figure for the budget review chronic and convalescent hospitals was 90.4 per cent. In the provinces the average percentage occupancy in the budget review general hospitals ranged from 74.1 per cent in Alberta and 74.6 per cent in Newfoundland to 82.3 per cent in Ontario, 82.2 per cent in British Columbia, and 81.3 per cent in Quebec. Variations in the percentage of occupancy in provinces are partly due to the size of hospitals; larger hospitals have generally higher rates of occupancy than small hospitals.

In 1963, there were 3,042,762 patients admitted to hospitals listed in hospital insurance agreements (Table 6), a rate of 161.0 admissions per thousand population. Discharges and deaths of patients in those hospitals amounted to 3,039,763, a rate of 160.9 separations per thousand population. The number of admissions per thousand population in the provinces ranged from 117.2 in Newfoundland and 141.0 in Quebec to 194.9 in Alberta and 226.4 in Saskatchewan. Similarly, the number of separations per thousand of population varied in provinces from 117.0 in Newfoundland to 226.1 in Saskatchewan.

Table 7 shows that the 1,261 hospitals listed in the federal-provincial agreements, and that reported employment in 1963, employed a total of 207,778 persons on a full-time basis and 23,044 persons on a part-time basis.

Tables 8, 9, and 10 deal with the gross operating costs of budget review hospitals. The gross operating costs or "revenue fund expenditures", which include some cost items that are not sharable under the federal-provincial agreements, amounted in 1963 to $878 million, or $27.06 per patient-day, in the budget review hospitals. Provincially they varied from $20.46 in Prince Edward Island to $28.84 in Quebec. Provincial differences between the per-patient-day costs of the budget review hospitals reflect, among others, differences in costs of labour and other items, and differences in the breadth and type of hospital services provided in the budget review hospitals. For example, some provinces provide a large proportion of the low per-patient-day cost geriatric and convalescent care in budget review hospitals, while in other provinces the bulk of this type of care is provided outside the budget review hospitals. Inclusion or exclusion of this low per-patient-day cost care in the operating costs of the budget review hospitals affects the total per-patient-day operating costs for those hospitals.

TABLE 6 - ADMISSIONS AND SEPARATIONS DURING YEAR IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, AND RATES PER 1,000 POPULATION(1), ADULTS AND CHILDREN, BY PROVINCE, 1963

Province	Number of hospitals reporting	Admissions during year		Separations during year	
		Number	Rate per 1,000 population	Number	Rate per 1,000 population
Newfoundland	46	56,352	117.2	56,292	117.0
Prince Edward Island	9	17,099	159.8	17,079	159.6
Nova Scotia	48	111,204	147.1	110,889	146.7
New Brunswick	40	105,950	172.6	105,861	172.4
Quebec	271	771,123	141.0	771,052	141.0
Ontario	321	1,009,102	156.5	1,007,587	156.3
Manitoba	103	175,689	184.9	175,525	184.8
Saskatchewan	160	211,275	226.4	210,958	226.1
Alberta	132	273,778	194.9	273,509	194.7
British Columbia	111	301,119	177.7	300,939	177.5
Yukon Territory	5	3,296	219.7	3,297	219.8
Northwest Territories	25	6,775	282.3	6,775	282.3
CANADA	1,271	3,042,762	161.0	3,039,763	160.9

(1) Based on 1963 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

TABLE 7 - TOTAL PERSONNEL EMPLOYED IN HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, BY PROVINCE, DECEMBER 31, 1963

Province	Number of hospitals reporting	Number of persons employed	
		Full-time	Part-time
Newfoundland	45	3,494	332
Prince Edward Island	9	938	69
Nova Scotia	48	7,954	606
New Brunswick	40	7,374	397
Quebec	268	60,370	4,819
Ontario	318	73,835	11,134
Manitoba	103	11,096	1,653
Saskatchewan	159	10,751	989
Alberta	132	15,538	1,260
British Columbia	111	15,938	1,709
Yukon Territory	3	147	33
Northwest Territories	25	343	43
CANADA	1,261	207,778	23,044

TABLE 8 - REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS, TOTAL, PER PATIENT-DAY(1), AND PER CAPITA(2), BY PROVINCE, 1963

Province	Number of hospitals reporting	Total expenditures	Expenditures per patient-day	Expenditures per capita
Newfoundland	40	$ 13,871,005	$23.34	$28.84
Prince Edward Island	9	3,591,564	20.46	33.57
Nova Scotia	47	30,366,474	27.36	40.17
New Brunswick	38	28,998,366	27.51	47.23
Quebec	165	247,140,470	28.84	45.20
Ontario	215	325,987,569	27.97	50.56
Manitoba	79	42,915,730	24.89	45.17
Saskatchewan	145	46,029,533	23.41	49.33
Alberta	124	64,752,983	23.28	46.09
British Columbia	91	73,998,737	26.42	43.66
Yukon Territory	2	175,085	45.32	11.67
Northwest Territories	1	275,551	27.80	11.48
CANADA	956	$878,103,067	$27.06	$46.47

(1) Patient-days during year for adults and children.
(2) Based on 1963 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

TABLE 9 - REVENUE FUND EXPENDITURES PER CAPITA(1) OF BUDGET REVIEW HOSPITALS, BY TYPE OF ACCOUNT, BY PROVINCE, 1963

Province	Departmental expense						Other revenue fund expense	Total revenue fund expense
	Salaries and wages	Medical and surgical supplies	Drugs	Raw food	Other supplies and expense	Total departmental expense		
Newfoundland	14.79	1.10	1.82	3.20	6.29	27.20	1.64	28.84
Prince Edward Island	18.17	1.13	1.28	2.64	6.80	30.02	3.54	33.57
Nova Scotia	22.85	1.24	1.52	2.81	8.72	37.14	3.02	40.17
New Brunswick	27.25	1.54	1.89	3.01	8.56	42.25	4.98	47.23
Quebec	28.89	1.38	1.84	2.51	6.89	41.51	3.69	45.20
Ontario	32.91	1.57	1.89	2.63	8.33	47.32	3.24	50.56
Manitoba	29.19	1.46	1.98	1.88	7.70	42.21	2.96	45.17
Saskatchewan	31.76	1.56	1.97	2.78	8.02	46.09	3.25	49.33
Alberta	28.73	1.42	1.63	3.16	6.33	41.27	4.81	46.09
British Columbia	29.22	1.35	1.59	2.31	6.57	41.04	2.62	43.66
Yukon	6.53	.20	.71	1.15	2.48	11.07	.60	11.67
Northwest Territories	6.25	.40	.37	.73	2.82	10.58	.90	11.48
CANADA	29.67	1.45	1.81	2.61	7.51	43.05	3.42	46.47

(1) Based on 1963 intercensal population estimates as at June 1, prepared by Dominion Bureau of Statistics.

TABLE 10 - PERCENTAGE DISTRIBUTION OF REVENUE FUND EXPENDITURES OF BUDGET REVIEW HOSPITALS, BY TYPE OF ACCOUNT, BY PROVINCE, 1963

Province	Departmental expense						Other revenue fund expense	Total revenue fund expense
	Salaries and wages	Medical and surgical supplies	Drugs	Raw food	Other supplies and expense	Total departmental expense		
Newfoundland	51.3	3.8	6.3	11.1	21.8	94.3	5.7	100.0
Prince Edward Island	54.1	3.4	3.8	7.9	20.3	89.4	10.6	100.0
Nova Scotia	56.9	3.1	3.8	7.0	21.7	92.5	7.5	100.0
New Brunswick	57.7	3.3	4.0	6.4	18.1	89.5	10.5	100.0
Quebec	63.9	3.0	4.1	5.6	15.3	91.8	8.2	100.0
Ontario	65.1	3.1	3.7	5.2	16.5	93.6	6.4	100.0
Manitoba	64.6	3.2	4.4	4.2	17.0	93.4	6.6	100.0
Saskatchewan	64.4	3.2	4.0	5.6	16.3	93.4	6.6	100.0
Alberta	62.3	3.1	3.5	6.9	13.7	89.6	10.4	100.0
British Columbia	66.9	3.1	3.6	5.3	15.0	94.0	6.0	100.0
Yukon	56.0	1.7	6.1	9.8	21.2	94.8	5.2	100.0
Northwest Territories	54.5	3.5	3.2	6.4	24.6	92.1	7.9	100.0
CANADA	63.9	3.1	3.9	5.6	16.2	92.6	7.4	100.0

The per capita national average operating cost of the budget review hospitals in 1963 amounted to $46.47. In provinces the per capita average operating costs varied from $28.84 in Newfoundland to $50.56 in Ontario. In addition to factors of costs of labour and types of services provided, which are mentioned above, the varying degree of intensity of utilization of hospital services is responsible for the variations in the provincial average per capita operating costs in the budget review hospitals. It should be noted that some provinces rely more heavily than others on contract and federal hospitals to provide some types of insured hospital care and this also is reflected in the provincial average per capita operating cost in budget review hospitals.

Hospitals are service-producing institutions and, as such, they use a high proportion of labour. Also, improvement and expansion of hospital services entail changes in the quality of skills and expansion in the number of employees. Table 10 shows that salaries and wages account for almost two-thirds of the revenue fund expenditures in the budget review hospitals. This item of expenditure, apart from being the largest, is also increasing at the fastest rate, reflecting the growing staff-patient ratio, the increase in costs per unit of work, and the need for both better qualified and more numerous staff to service the increasing population of Canada.

Table 11 deals with hospital utilization by age and sex and Table 12 relates to hospital utilization by class of disease. Much additional information can be found in the annual reports of the provincial hospital insurance plans.

Subsection 4 - Dominion Council of Health

The Dominion Council of Health is the principal advisory agency to the Minister of National Health and Welfare on federal-provincial health matters. Its membership includes the Deputy Minister of National Health, who acts as chairman, the chief health officer of each province, and five appointees of the Governor-in-Council representing the universities, labour, agriculture, and organizations of French and English-speaking women. The Council meets semi-annually. Federal-provincial technical advisory committees of the Council deal with specific aspects of public health.

TABLE 11 - HOSPITALIZATION, BY AGE AND SEX, FOR IN-PATIENTS(1) INSURED BY PROVINCIAL HOSPITAL INSURANCE PLANS,(2) 1963

	0-4	5-14	15-24	25-44	45-64	65-69	70+	Age unknown	Total
Separations									
Male	204,815	179,956	107,564	207,919	250,962	57,962	151,453	36	1,160,667
Female	151,694	155,073	369,772	654,071	265,297	52,832	141,007	31	1,789,777
Total	356,509	335,029	477,336	861,990	516,259	110,794	292,460	67	2,950,444
Separations per 1,000 population									
Male	175.0	85.6	74.6	84.9	149.4	238.7	338.7	-	121.7
Female	135.7	77.2	261.6	269.1	161.9	207.6	283.3	-	191.2
Total	155.8	81.5	167.2	176.6	155.6	222.8	309.5	-	156.1
Patient-days since admission									
Male	1,687,766	1,086,857	890,907	2,179,626	3,920,111	1,225,608	4,037,398	400	15,028,673
Female	1,267,741	908,557	2,337,707	5,081,918	3,976,493	1,120,860	4,823,085	252	19,516,613
Total	2,955,507	1,995,414	3,228,614	7,261,544	7,896,604	2,346,468	8,860,483	652	34,545,286
Days since admission per 1,000 population									
Male	1,441.7	517.0	617.9	889.8	2,333.3	5,047.8	9,028.2	-	1,576.3
Female	1,133.7	452.4	1,653.7	2,090.7	2,427.1	4,404.2	9,690.7	-	2,084.8
Total	1,291.2	485.4	1,130.7	1,487.9	2,379.6	4,718.4	9,377.2	-	1,828.2
Average stay of separations (days)									
Male	8.2	6.0	8.3	10.5	15.6	21.1	26.7	11.1	12.9
Female	8.4	5.9	6.3	7.8	15.0	21.2	34.2	8.1	10.9
Total	8.3	6.0	6.8	8.4	15.3	21.2	30.3	9.7	11.7
Population									
Male	1,170,700	2,102,100	1,441,900	2,449,600	1,680,100	242,800	447,200	-	9,534,400
Female	1,118,200	2,008,500	1,413,600	2,430,700	1,638,400	254,500	497,700	-	9,361,600
Total	2,288,900	4,110,600	2,855,500	4,880,300	3,318,500	497,300	944,900	-	18,896,000

(1) Excludes newborn.

(2) Newfoundland, Prince Edward Island, and Manitoba also include non-insured residents of the province; Quebec and Ontario include both resident and non-resident non-insured in-patients; Alberta includes insured resident in-patients and 6,438 non-insured residents.

Source: Data supplied by the provinces to the Department of National Health and Welfare.

TABLE 12 - HOSPITALIZATION, BY CLASS OF DISEASE, OF IN-PATIENTS(1) INSURED BY PROVINCIAL HOSPITAL INSURANCE PLANS,(2) 1963

Class of disease(3)	Separations		Days of care for separations		Average stay of separations	Percentage distribution	
	Total	Per 1,000 population	Total	Per 1,000 population		Separations	Days of care
All diseases	2,929,599	155.0	34,123,564	1,805.9	11.6	100.0	100.0
I. Infective and parasitic diseases	42,668	2.3	587,888	31.1	13.8	1.5	1.7
II. Neoplasms	154,465	8.2	2,902,549	153.6	18.8	5.3	8.5
III. Allergic, endocrine system, metabolic and nutritional diseases	81,017	4.3	1,262,292	66.8	15.6	2.8	3.7
IV. Diseases of the blood and blood-forming organs	15,969	0.8	252,520	13.4	15.8	0.5	0.7
V. Mental, psychoneurotic, and personality disorders	70,359	3.7	1,271,632	67.3	18.1	2.4	3.7
VI. Diseases of the nervous system and sense organs	138,279	7.3	3,722,450	197.0	26.9	4.7	10.9
VII. Diseases of the circulatory system	224,574	11.9	4,796,796	253.9	21.4	7.7	14.1
VIII. Diseases of the respiratory system	469,898	24.9	3,132,352	165.8	6.7	16.0	9.2
IX. Diseases of the digestive system	389,285	20.6	4,008,541	212.1	10.3	13.3	11.7
X. Diseases of the genito-urinary system	233,055	12.3	2,276,675	120.5	9.8	8.0	6.7
XI. Deliveries and complications of pregnancy, childbirth and the puerperium	593,127	31.4	3,388,349	179.3	5.7	20.2	9.9
XII. Diseases of the skin and cellular tissue	60,130	3.2	605,171	32.0	10.1	2.1	1.8
XIII. Diseases of bones and organs of movement	98,378	5.2	1,867,974	98.9	19.0	3.4	5.5
XIV. Congenital malformations	27,042	1.4	422,495	22.4	15.6	0.9	1.2
XV. Certain diseases of early infancy	10,593	0.6	136,610	7.2	12.9	0.4	0.4
XVI. Symptoms, senility, and ill-defined conditions	69,123	3.7	598,047	31.6	8.7	2.4	1.8
XVII. Accidents, poisonings, and violence	251,637	13.3	2,891,223	153.0	11.5	8.6	8.5

(1) Excludes newborn.

(2) Newfoundland, Prince Edward Island, and Manitoba also include non-insured residents of the province; Quebec and Ontario include both resident and non-resident non-insured in-patients; Alberta includes insured resident in-patients and 6,438 non-insured residents.

(3) According to "International Statistical Classification of Diseases, Injuries and Causes of Death, 1955."

Source: Data supplied by the provinces to the Department of National Health and Welfare.

Section 3 - Provincial and Local Health Services

Provincial and local health services may be grouped into several broad categories: general public health services, primarily of a preventive nature; services for specific diseases or disabilities, combining prevention and treatment; services related to general medical and hospital care; and services for disabled and chronically ill persons.

Subsection 1 - General Public Health Services

Provincial and local governments co-operate closely in providing community public health services. The autonomy of the provinces and their social, economic, and geographic diversity make for some variety in legislative provisions, in financial arrangements, and in the detailed division of functions between provincial health departments and local and voluntary agencies. Each province, however, offers all or nearly all of a basic range of public health services that includes environmental health, occupational health, communicable disease control, maternal and child health, dental health, nutrition, health education, and public health laboratories.

Environmental health. - The control of factors in the environment that are harmful to physical health is a rapidly expanding area of public health activity. Much of the work in community sanitation involves traditional inspection duties essential to the maintenance of pure milk, water, and food supplies, sewage disposal systems, and sanitary conditions in public areas. Increasing industrialization and urbanization, however, have both magnified the old problems and imposed new responsibilities. Air pollution, water pollution, radiation exposure, and the use of pesticides are emerging as major environmental problems, necessitating the co-operative efforts of governments and other agencies in research and in planning effective control measures.

Occupational health. - Services designed to prevent accidents and occupational diseases and to maintain the health of employees are the common concern of provincial health departments, labour departments, workmen's compensation boards, and industry management. Provincial agencies regulate working conditions and offer consulting and educational services to industry. All provinces have legislation (Factory Acts, Shop Acts, Mines Acts, Workmen's Compensation Acts) setting health safety standards for employment.

Communicable disease control. - There are separate divisions of epidemiology or communicable disease control in six provinces; in the other provinces these functions are handled by other provincial medical consultants. Local health authorities undertake casefinding and diagnostic services in co-operation with public health laboratories, carry out epidemiological investigations and often participate in tuberculosis and venereal disease control measures. All provincial health departments organize immunization programs for the public against diphtheria, tetanus, poliomyelitis, whooping cough, and smallpox. Through agreement with the federal government, live oral poliovirus vaccine (Sabin) as well as Salk vaccine is made available by provincial health departments for immunization against poliomyelitis. Other agents such as gamma globulin may be provided under certain conditions for protection against measles and infectious hepatitis.

Maternal and child health. - Most provincial health departments have Maternal and Child Health Divisions under medical direction or have made other administrative arrangements to provide consultant services in this field. In addition, six of the provinces have consultant nursing services within these divisions. Provincial divisions provide advisory services to local health departments and to hospitals, conduct studies of local problems and needs, and assist in the training of health personnel.

Dental health. - All provincial health departments have dental health divisions that administer programs varying under local conditions but directed almost entirely to health education and the care of children. Training of dentists and dental hygienists in public health, the operation of children's preventive and treatment clinics, and health education are primary concerns in all provinces. Water fluoridation projects involving a total of 4,050,100 people are in operation in eight provinces and in the Northwest Territories. Four provinces --Alberta, Manitoba, Ontario, and Nova Scotia--have set up, in conjunction with their dental schools, special courses for dental hygienists. In all ten provinces clinical care is provided for children in remote rural areas. A locally-sponsored plan in which the cost of dental services for children is shared by the community and the provincial health department is in operation in more than 90 communities in British Columbia.

Nutrition. - Services include technical guidance, education, consultation, and research. In some provinces, school lunch programs are sponsored and dietary supplements distributed. Five provinces have special nutrition divisions; in other provinces, consultants in nutrition function under a broader grouping of departmental services.

Health education. - A basic concern of provincial health information services is to stimulate public interest in important health needs, and in most provincial health departments a Division of Health Education is established for this purpose. Directed by a professional full-time 'health educator', it may also provide consultative services to the management of the Department, to local health authorities, and to voluntary associations.

Public health laboratories. - The public health laboratory was one of the earliest provincial services developed to assist local public health departments in the protection of community health and the control of infectious diseases. Public health bacteriology (testing of milk, water, and food), diagnostic bacteriology, and pathology are the principal functions of the laboratory service, with medical testing for physicians and hospitals steadily increasing in volume. Efforts to co-ordinate public health and hospital laboratory services and measures to bring laboratory facilities to rural areas are among the notable developments in recent years.

Local health organization. - Local health authorities are responsible generally for the administration and enforcement of local regulations and by-laws relating to health and for the direct provision of various preventive public health services. The scope of preventive services varies greatly in different areas and provinces, but basic programs are similar, covering environmental sanitation, communicable disease control, child, maternal, and school health, health education, and vital statistics.

Environmental sanitation - relates to supervision of water, milk, and food supplies, the disposal of human and industrial wastes, housing, recreation areas, and places of employment. Local work is done mainly by sanitary inspectors who inspect milk producing establishments, plumbing, waste disposal units, housing facilities, sanitation in hotels and other public places, lighting and ventilation in schools and so or

Communicable disease control - includes diagnostic services in co-operation with public health laboratories, immunization against diseases such as smallpox, diphtheria, and whooping cough, epidemiological investigations to determine the sources of infection, and isolation and quarantine enforcement. Local health staff often participates also in tuberculosis and venereal disease control measures.

Child and maternal health - is the major function of the public health nurse. Activities may include prenatal education, health supervision of infants and pre-school children through home visits, child health clinics and conferences, and school health services.

Health education - is to assist the individual and the community to achieve higher standards of health. Information is made available through films, pamphlets, radio broadcasts, public lectures and classes, and newspaper releases.

Vital statistics - are collected locally and information is used to analyse and plan public health activities. Among other services provided locally by some health units or departments are mental health, occupational health, community nutrition, and preventive dental health. Increasing attention is being directed towards measures designed to control the chronic diseases, to extend the period of active life, and to provide adequate public health protection for the aging segment of the population.

Health units. - Full-time local public health services under the direction of full-time medical health officers have been developed partly through municipal health departments, partly through joint provincial-local health units, and partly through provincial health districts. City health departments are administered and financed directly by the municipality concerned, usually through a municipal board of health. Local health units are designed primarily for rural areas with staff serving county or other combinations of local government jurisdictions, and financial and administrative responsibility shared between provincial and local authorities; while the division of responsibility varies among provinces, the trend is toward an increasing degree of provincial control. In some provinces (mainly in the Atlantic provinces) provincially administered local health districts provide services without administrative participation by local citizens.

At the end of 1963, full-time local public health services were supplied through 30 urban health departments covering 6.0 million persons and 186 local health units covering 9.7 million persons. The total number of full-time health departments, units, and districts had increased to 216 in 1963 from 157 in 1948. The basic staff of an urban health department or local health unit usually comprises a medical officer of health, some public health nurses, and sanitary inspectors. To a great extent the services provided depend upon having a sufficient number of qualified persons employed by the agency. Total full-time staff employed by local agencies at the end of 1963 numbered 5,288, of which 2,351 were in urban health departments and 2,937 were employed by local health units. Many areas not requiring full-time services of health personnel employ part-time personnel but more often these services are provided directly to the local area by the provincial health department. In addition, provinces are responsible for providing local health services in municipally unorganized territories.

Subsection 2 - Services for Specific Diseases or Disabilities

Mental health. - Treatment programs for the mentally ill have centred mainly around three types of facilities: the mental hospital, the psychiatric unit in the general hospital, and the organized community mental health clinic. These facilities, however, no longer have separate and distinct functions. New emphasis on the role of the community and its resources in the treatment and rehabilitation of the mentally ill is affecting the whole program of in-patient care. Utilizing the basic clinical facilities of general hospitals and mental hospitals the community program is extending its scope and usefulness through the provision of day-care centres, sheltered workshops, half-way houses, and foster home and boarding home care. More than 60 general hospitals in Canada have organized psychiatric units providing bed accommodation for more than 2,000 patients. Further planning in community-based services concerns the development of small regional psychiatric hospitals from which a comprehensive community program will emanate. Examples of this type are the new 150-bed hospital in Yorkton, Saskatchewan, a 68-bed psychiatric hospital in Selkirk, Manitoba, and the developing community facilities for in-patient, out-patient, and day care in Ottawa, Sudbury, and Windsor.

Special centres for the assessment and diagnostic evaluation of mentally retarded children are also being developed. Day-training schools or classes for the trainable retarded, sponsored by some 250 local associations of parent groups forming the Canadian Association for Retarded Children, are now organized throughout the land.

Most public mental hospitals provide care and treatment for all types of mental illness. New programs of recreational and industrial therapy and enlarged and modernized clinical and surgical facilities are examples of widespread improvements in mental hospital care that particularly benefit patients undergoing active treatment. More recently planning has been undertaken to reassess the status of the long-term chronically ill patient. Since 1961 new legislation governing the admission and care of the mentally ill has been enacted in four provinces - Saskatchewan, Alberta, British Columbia, and Manitoba - that is designed to promote easier and more informal methods of admission and discharge and to establish machinery guaranteeing periodic review of the medical certification of long-term patients.

A great part of the cost of care in mental hospitals is borne by the provincial governments, although a charge, according to ability to contribute, may be made in some provinces. Newfoundland and Saskatchewan provide complete free care; Manitoba covers minimum maintenance costs for all patients; in Nova Scotia the provincial hospital gives free care to patients requiring active treatment; and in Ontario mental-institution treatment is included in the hospital care insurance plan.

Tuberculosis. - The fight against tuberculosis is one of the major programs of all health departments. Free hospitalization and free drug treatment, both on an in-patient and a domiciliary basis, is provided. In two provinces extensive BCG programs are in effect and in the other provinces this prophylactic is provided to groups at special risk. Case-finding programs in the form of community tuberculin and X-ray surveys, surveys of high risk groups, and the follow-up of all arrested tuberculosis cases are routine. These activities have resulted in a decline in the Canadian tuberculosis death rate of 83 per cent since 1951. In 1963 the rate was 4.0 per 100,000 population. The number of beds set up in sanatoria declined from a peak of 18,977 in 1953 to less than 8,000 in 1964.

Cancer. - Health departments and lay and professional groups working for the control of cancer have been concerned mainly with four aspects of problem--diagnosis, treatment, research, and public education. In cancer detection and treatment, specialized medicine, hospital services, and an expanding public health program are closely related. There are programs operating under health departments in four provinces; four others have provincially supported cancer agencies or commissions. These sponsor the work of diagnosis and treatment in special clinics, located usually within the larger general hospitals. Under all the provincial hospital insurance plans, the benefits pertaining to in-patient care in the treatment of cancer are essentially similar and include such special services as diagnostic radiology, laboratory tests, and radiotherapy. Similar services for out-patients are covered either by hospital insurance or by federal-provincial Cancer Control grants. Comprehensive free medical programs for cancer patients are in operation in Saskatchewan and Alberta and for cancer in-patients in New Brunswick.

Venereal disease. - Free diagnostic and treatment services are available in all provinces but the operation of government clinics is being increasingly superseded by the method of supplying free drugs to private physicians who are reimbursed for treatment of indigents on a fee-for-service basis.

Alcoholism. - Ontario, Manitoba, Alberta, and British Columbia carry out research and education programs and operate centres for treatment, supported largely by public funds. Ontario, Saskatchewan, and Alberta also have rehabilitation programs for alcoholic inmates of reform institutions. Legislation in Newfoundland, New Brunswick, Nova Scotia, and Quebec authorizes the setting up of similar agencies to initiate research and education studies in those provinces.

Other diseases or disabilities. - Services for persons with chronic disabilities, such as heart disease, arthritis, diabetes, visual and auditory impairments, and paraplegia have been developed largely by voluntary agencies assisted by federal and provincial funds. A brief description of the programs of some of these agencies is given in Part IV, commencing on page 117, which deals with national voluntary health and welfare activities, and in the subsection on Services for the Disabled and Chronically Ill starting at page 54.

Subsection 3 - Public Medical Care Programs

Saskatchewan, Alberta, and British Columbia now operate, and Ontario plans to commence to operate in 1966, Public Medical Care Insurance Schemes available to their entire populations. These same provinces and Nova Scotia and Manitoba have also been operating other systems of financing the cost of health care provided to recipients of public assistance. The public assistance schemes have remained in existence concurrently with the newer programs.

About half of the population of Newfoundland receives physicians' services at home or in hospital under the provincially administered Cottage Hospital Medical Care Plan that is financed in part on a premium basis. Medical indigents not under the plan may also receive care at provincial expense. In addition, all Newfoundland children under the age of 16 years are entitled to free medical and surgical care in hospital.

Medical Care Insurance Plan in Saskatchewan. - Almost every Saskatchewan resident of three months or more is required to become a beneficiary of the Medical Care Insurance Plan by paying a premium or by having it paid on his behalf.

Certain classes of residents are eligible for services but are exempt from premium payment; others are exempted from the premium and are also ineligible for the insured services.

Indians who live on reserves, or who have lived apart from reserves for less than 12 months, neither pay premiums not receive benefits (negotiations with the federal government to include them as beneficiaries were continuing as of September 1965; meanwhile they receive medical care under existing contractual arrangements with individual physicians). Members of the armed forces and the Royal Canadian Mounted Police and recipients of War Veterans' Allowances are also exempt from premiums and ineligible for benefits. However, their spouses and dependents, if resident in Saskatchewan, are eligible for coverage, and premiums are required to be paid on their behalf. Patients in mental hospitals and tuberculosis sanatoria and inmates of penitentiaries and provincial jails are not required to pay premiums. Recipients of federal Old Age Security and Blind Pensions who qualify for the Saskatchewan supplemental allowances, Aid-to-Dependent-Families recipients, and provincial government wards are outside the program but continue to receive medical coverage as part of the health services provided under the existing program for recipients of public assistance. Recipients of Old Age Assistance (65-69 age-group) have their medical care insurance premiums paid by the province. Recipients of municipal social aid normally have their medical care insurance premiums paid on their behalf by the municipality they live in.

Insured persons are entitled to have payments made for the services of their physician-of-choice, without limit as to age or pre-existing conditions. The services, whether in office, home, or hospital, include:

Medical care - the diagnosis and treatment of all medical disabilities and conditions.

Surgery - surgical procedures, including diagnosis, preoperative and postoperative care, and, when required, the services of a surgical assistant.

Obstetrics - care of the mother during pregnancy, delivery, and the postnatal period.

Newborn care - all care required by the newborn.

Specialist's services - insured at specialist's rates when the beneficiary is referred by another physician; at general practitioner's rates when not so referred, except that if the service is within the specialist's field of practice and is one for which the Schedule of Fees of the College of Physicians and Surgeons lists only a "Specialist Fee", the payment is calculated at the specialist's rate even if the beneficiary was not referred to the specialist by another physician.

Anaesthesia - the administration of anaesthesia in conjunction with diagnostic, surgical, obstetrical, dental, and other procedures that are otherwise insured.

Laboratory - all laboratory services, including interpretations, performed by a specialist in pathology in a non-hospital facility; also, a restricted list of laboratory services performed, in their offices, by physicians who are not pathologists.

Radiology - X-ray services, including interpretations, performed by a specialist in radiology in a non-hospital facility.

Preventive medicine - inoculations and vaccinations where not provided through any government agency, and routine physical examinations when not for the purpose of marriage, employment, insurance, nor at the request of any third party.

Dentistry - where performed by a dentist in support of a surgeon performing maxillo-facial surgery.

All services insured in Saskatchewan are also insured when provided outside the province. Payment for out-of-province benefits is limited to the rates payable within the province, and is made to the beneficiary on a reimbursement basis.(1)

Plastic surgery for cosmetic purposes, refractions, appliances, dentistry except as specified above, drugs, and special duty nurse and ambulance service are excluded from the program, as normally are services already provided under other provincial and federal legislation, such as the provincial Tuberculosis Sanatoria and Hospitals Act, the Mental Health Act, the Cancer Control Act, and the Venereal Disease Prevention Act, and the Federal National Defence Act and Veterans Rehabilitation Act. Physiotherapy, formerly a benefit, has been excluded from the program since July 1, 1965.

Saskatchewan physicians providing insured medical services may elect to receive payment in any of several ways:

(1) They may contract for a salary or similar arrangement;

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(1) Until 1964 out-of-province psychiatry was not a benefit except in an emergency.

(2) They may choose to receive direct payment from the administering public agency, the Medical Care Insurance Commission, at 85 per cent of the 1959 Schedule of Minimum Fees (as amended to 1963) of the College of Physicians and Surgeons of Saskatchewan, and agree to accept the Commission payment as payment in full (subject to the exception noted below);

(3) A physician may choose to become a member of an approved health agency. He thereby agrees to submit to that agency all bills for services provided to its subscribers. The agency, in turn, submits the bills to the Commission, and receives payment from it at 85% of the assessed fee, which payment it then forwards to the physician. In submitting an account to an approved health agency, a physician agrees to accept payment as payment in full, except that a specialist consulted by a non-referred patient can bill the patient for the difference between the general practitioner fee and the specialist fee;

(4) Where the patient (or the doctor) is not a member of an approved health agency (or they are not members of the same one) and the doctor chooses not to bill the Commission directly, he may submit his bill to the patient. If the bill is itemized, the patient may submit it to the Commission and receive payment for insured services at 85 per cent of the assessed fee. The doctor may charge the patient an amount over-and-above what the patient receives from the Commission. If, however, the doctor refuses to provide the patient with an itemized bill, the Commission will not pay any portion of the account.

Financing

The provincial program is financed from the personal premiums plus general revenue contributions. No premiums were levied in respect of 1962. For 1963 the annual levies were $12 per adult and $24 for a family (dependents include persons under 18 years at the end of the preceding year or under 21 and at school, or sons and daughters of any age who are dependent by reason of physical or mental infirmity). The premiums were reduced to $6 and $12 respectively for 1964, and were raised again in 1965 to $12 and $24 respectively. Special corporation and personal income taxes have been introduced to help support the program along with the use of a portion of revenues of a 5 per cent retail sales tax. In 1964, 15 per cent of payments were financed by personal premiums, 83 per cent by grants from the provincial consolidated revenue fund, and 2 per cent by interest, miscellaneous receipts, and recoveries of advances.

The Swift Current Health Region

The former municipal-doctor plans in Saskatchewan were discontinued in July 1962, but special arrangements were made to continue, under local auspices, insured medical services for some 54,000 residents of the Swift Current Health Region, which had operated a prepaid medical-dental program since 1946. The new agreement between the Region and the Commission, as of January 1, 1963, provided:

(1) That payment for all insured services for beneficiaries in the region be made by the Region Board (the executive body) through its contracts with the Swift Current and District Medical Society and individual physicians;

(2) That, for 1963, the Commission remit to the Board all medical care premiums collected from region residents, less collection costs;

(3) That, for 1964 and after, region residents be exempt from paying provincial medical care premiums and the Board have the authority to levy its own personal tax for medical care;

(4) That, beginning in 1963, the Commission pay to the region a per capita grant based on the per capita cost of medical care insurance in the province outside the Swift Current Health Region, less per capita premium revenue.

The effect of this new arrangement is to provide the region with a basic per capita income that is related to the amount spent per capita on behalf of other residents of the province. The balance of any sums required to operate the regional program is raised by the Board's personal tax levy on region residents.

As requested by the Region Board, the contract specifically permits the continuation of utilization fees in the region that are not in effect elsewhere. The Board may no longer, however, levy property taxes for support of medical care services.

The Board continues to provide a salaried radiological service, and a dental program, emphasizing prevention for children under 12 years of age. This program is carried on by dentists operating from three permanent dental clinics.

Coverage, utilization, and costs

The population of Saskatchewan covered under the Medical Care Insurance Plan, including the Swift Current Health Region, was 879,224 as of June 30, 1964, or 93.2 per cent

of the total population. (The Swift Current Plan accounted for 54,067 of these.) In addition to these plans, another 6.6 per cent of the population of Saskatchewan was covered for comprehensive benefits by other programs, federal and provincial, as discussed in the Section "Eligibility and Coverage" above.

Unless otherwise noted, the following statistics relate to the calendar year 1964, and exclude the Swift Current Health Region.

About 602,000 residents received benefits exceeding $20.4 million during the year. Of this amount $13,871,000 was paid through approved health agencies, $4,246,000 paid directly to physicians and physiotherapists, and $2,322,000 directly to patients.

The per beneficiary payment for insured services, excluding administrative costs, was $24.67. Cost of administration for 1964 was $1.34 per beneficiary.

Payment for one or more services was made to 602,000 individual beneficiaries, comprising 73 per cent of the covered population. Of families covered, 87 per cent received one or more services. Members of 13 per cent of the families did not visit a doctor during the year for insured benefits. For the families receiving benefits the average payment was $75.

About 49 per cent of all families received benefits of $50 or less; nearly 17 per cent, $50 to $100; and nearly 14 per cent, $100 to $200. Payment on behalf of 7 per cent of families ranged from $200 to $500, and, for less than one per cent, exceeded $500.

Of the 911 Saskatchewan physicians who provided at least one service for which the Commission made payment, 72 per cent were general practitioners and 28 per cent specialists.

Of the 4,090,000 individual services for which payment was made, 21.8 per cent were provided by specialists and 78.2 per cent by general practitioners. The cost to the Commission for these services was: specialist services, $7,348,000; general practitioner services, $13,007,000.(1) The overall average payment per service was $4.76 for males and $5.15 for females.

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(1) Physiotherapy services, which were 2 per cent of all services, and 2 per cent of payments, are distributed among specialist and general practitioner payments.

Age groups having the highest incidence of service were infants under 1 year and persons over 65. In each of these groups, the number of services per beneficiary was two to two-and-one-half times the average, although the average payments per service were among the lowest.

Children 1-14 received fewer services per capita than any other age group. The services provided to women in the 25-44 age group were the most costly to insure, at $6.46 per average payment compared with $5.08 for males in this age group.

Forty-two per cent of all services were initial or repeat office visits. Another 24 per cent were hospital visits and an additional 6 per cent home and emergency calls. Altogether, home, office, and hospital visits represented 72 per cent of all services and 47 per cent of insurance payments. Diagnostic and laboratory tests accounted for 15 per cent of all services.

From 80 to 90 per cent of home, office, and hospital calls were made by general practitioners and the balance by specialists. Surgical procedures made up 4 per cent of all services but accounted for 26 per cent of payments. General practitioners provided 72 per cent of surgical services and specialists 28 per cent. Payments for surgery, however, were equally divided between specialists and general practitioners.

The Alberta Medical Plan.

The Alberta Medical Plan came into effect on October 1, 1963. The aim of the Plan is to make comprehensive medical care services insurance available to all residents of the province, through the medium of the existing health insurance industry. In order to be approved for participation in the Plan, each agency selling health insurance in the province must offer to all residents a standard policy, without any exclusions because of age, pre-existing health conditions, or the previous cancellation of a policy with another agency because of abuse. The policy must be guaranteed renewable, and must provide a specified "basic benefit" package of comprehensive medical-care services. It must provide either first-dollar coverage, or a deductible of $25 per person ($50 maximum for a family) with a twenty per cent co-insurance provision.

A program of subsidies is incorporated into the Plan to assist certain persons with little or not taxable incomes in the purchase of their medical insurance.

Eligibility and coverage:

Any resident of the province is eligible to purchase the standard medical care insurance contract, with the exception that any approved agency may limit its liability, in the case of a person already insured for medical services, to the difference between what is covered under the other contract and the assessed insurable costs for medical services incurred by him.

As of May 1965, the total number of persons covered under the Alberta Medical Plan was 831,000, or 57.4 per cent of the estimated population at April 1, 1965. Another 113,000 persons, 7.8 per cent of the population, comprising, among others, members of the armed forces, Indians, and persons covered by the Pensioner Medical Fund, were insured under separate provincial or federal government programs for comprehensive medical benefits comparable to those provided by the Alberta Medical Plan. The Alberta government reports that somewhat more than 157,000 additional persons, 10.8 per cent of the population, were covered by medical services insurance that is not part of the Alberta Medical Plan, but that is sold by insurance companies.

Benefits and waiting periods:

Under the Alberta Medical Plan, approved insurance carriers must offer medical insurance contracts that provide the following benefits:

1. - Treatment and care provided by or under the supervision and direction of a physician, including preventive, diagnostic, and therapeutic care, and consultant and anaesthetist services.

2. - Standard laboratory, radiological, and diagnostic services have been benefits under the Plan from its inception. Since August 1, 1965, however, 80 per cent of the cost of these services, when supplied at hospitals or private clinics or laboratories, has been paid for all Alberta residents as a benefit under the provincial hospital insurance plan. Coverage under the Alberta Medical Plan will pay the remaining 20 per cent of the cost of these services. The government of Alberta has requested that the insurance carriers make a reduction of at least 10 per cent in their premiums as a result of the province's picking up the 80 per cent of costs for which the carriers were previously responsible.

3. - After being covered by a standard non-group contract for at least 12 months, treatment of psychiatric conditions, including psychotherapy and shock therapy, provided by a physician in private practice.

4. - Under a standard group contract, treatment of mental diseases, but without the waiting period.

5. - Under any contract that has been in force for two years, an annual routine health examination.

6. - Pre-natal and post-natal care and delivery, provided that conception occurred after the effective date of coverage of the person.

In addition to the exceptions noted above a waiting period of three months during which no benefits are available commences on the date application for insurance is made and the first premium paid; the end of this waiting period is the effective date of the contract.

Among services excluded from the Plan are: services not provided by nor under the direction or supervision of a physician; sterilization for reasons other than of health; drugs, medicines, artificial aids and appliances; examination of eyes for the fitting of glasses; glasses; and dental care.

Financing:

The Alberta Medical Plan is financed out of personal premiums. Maximum annual premiums have been set by government regulation for first dollar coverage, at $63 for a single person, $126 for a family of two persons, and $159 for a family of three or more persons. For contracts with deductible and co-insurance features, maximum premiums are $42, $84, and $114, respectively.

Contracts may be of two types with respect to enrolment; a standard contract sold to individuals, and a group standard contract sold to the members of a group. Under a standard contract each particular carrier at any point in time must be charging the same premiums to either every enrolled resident in a community, or every enrolee who was of a given age when he entered that carrier's plan, except that an enrolee's premium may be increased to the maximum level when he reaches age 65. The premium charged to a subsidized individual must be reduced by the amount of subsidy received for him. When a person aged under 65 becomes totally disabled (so as to be unable to work at all for remuneration), an approved carrier must waive his premium for the period of his disability up to six months.

Subsidies:

Persons purchasing health insurance under the Alberta Medical Plan may, by applying, have their premiums subsidized by the provincial government if they have no taxable income or, to a lesser extent, if their taxable income is not more than $500. For persons with no taxable income, the subsidy is $18 for a single person, $42 for a family of two, and $72 for a family of three or more. For persons with some taxable income but not more than $500, subsidies are half those amounts.

Subsidies are paid by the government to the approved carrier upon presentation to the government by the carrier of a statement, signed by the applicant, declaring that he has become insured with the carrier and that his taxable income for the previous calendar year places him in one of the groups eligible for subsidy.

In May 1965, 187,068 persons, 23 per cent of all persons insured under the Alberta Medical Plan, were covered by subsidized medical insurance contracts.

Payment of Doctors:

A doctor is paid either his charged fee or the fee listed in the most recent schedule of fees published by the College of Physicians and Surgeons of Alberta, whichever is lesser. However, a doctor having an agreement with the doctor-sponsored Medical Services (Alberta) Incorporated, who treats a patient insured by MS(A)I, agrees to accept 90 per cent of the schedule-fee as payment in full, unless there is pre-arrangement with the patient for extra-billing.

Administration:

The selling of insurance, the collecting of premiums, and the paying of claims are the responsibility of the approved health insurance carriers, of which there were 38 active in February 1965. There was one non-profit carrier, MS(A)I, and 37 commercial companies. MS(A)I covered 81 per cent and the commercial companies 19 per cent of the persons insured under the Alberta Medical Plan in May 1965.

Several special agencies were established by regulation under the Act setting up the Alberta Medical Plan.

A Co-ordinating Directorate, consisting of one representative each of the Minister of Health, the Alberta College of Physicians and Surgeons, the Canadian Health Insurance Association, and Medical Services (Alberta) Incorporated, under the chairmanship of the representative of the

Minister, is in charge of general regulation of the Plan and of making recommendations to the Minister concerning matters such as approval of carriers and legislative changes in the Plan.

An Assessment Committee, composed of one representative of the commercial insurance companies, one of M.S.(A)I, and three representatives of the College of Physicians and Surgeons, was set up to mediate problems arising between physicians and approved carriers.

A non-profit organization, Alberta Medical Carriers Incorporated (A.M.C.I.), to which every approved carrier must belong, was established to operate the pooling arrangements, required under the Plan, for persons 65 and over and extra-risk cases under 65.

Under normal circumstances every approved carrier must participate in the pooling arrangements, whereby all carriers share in the added financial cost of insuring persons with poor health records. A.M.C.I., with the approval of the Co-ordinating Directorate, may change the maximum premium levels from time to time.

Statistics:

Records relating to covered persons may be published by the carriers in statistical form, preserving the anonymity of individual persons included. The Co-ordinating Directorate is permitted to collect statistics on the entire Alberta Medical Plan, since the carriers are required to compile and make available to the Directorate reasonable statistical information.

The British Columbia Medical Plan.

The British Columbia Medical Plan, which became effective on September 1, 1965, is a new agency created, under the Medical Grant Act of March 1965 and its regulations, to make medical insurance available to all individuals and to help persons with little or no taxable income pay their premiums.

Eligibility: Any resident of the province is eligible to purchase medical insurance under the Plan.

Benefits: Benefits include payment of medical and surgical services of a physician or osteopathic physician of the subscriber's choice, when required for preventive medicine, diagnosis, or therapy; specialist and consultant services at full rates upon referral and at general practitioner rates without referral; anaesthetic services; and necessary

laboratory services and diagnostic aids, including X-ray. Coverage is provided within stipulated limits for chiropractic therapy, naturopathic therapy, physiotherapy, and special nursing services.

Among excluded services are examination of the eyes for eyeglasses, dental services, podiatrist's and chiropodist's services, transportation, and routine or periodical medical examinations.

Premiums: Annual premiums of the British Columbia Medical Plan are $60 for a single person, $120 for a family of two, and $150 for a family of three or more.

Subsidies: A person who had taxable income not in excess of $1,000 in the preceding year may apply for a government subsidy to pay part of his medical insurance premium, provided that he maintained permanent residence in the province for the previous 12 months, is not principally dependent on another person, and does not have his medical care needs provided for by the provincial or federal government. The subsidy is half of the premium for a person with no taxable income and one-quarter of the premium for one with a taxable income between $1 and $1,000. Persons who are exempt from liability to pay income tax because of special status or membership are not eligible for government subsidy under the program.

Payment of Physicians: Physicians will be paid under the program "a minimum of 90 per cent" of the fees listed in the current schedule of the provincial College of Physicians and Surgeons. The British Columbia Medical Association and the government have agreed that there will be a revision of the fee schedule every two years beginning January 1, 1967. The schedule will be adjusted according to an agreed-upon formula that takes into account movements in the industrial composite index of average weekly wages and salaries in British Columbia and the consumer price index for Vancouver.

Administration: The Plan is administered by a six-member board of directors. Board members are appointed by the government, three upon the recommendation of the Provincial Secretary and three upon the recommendation of the British Columbia Medical Association. One of the directors is appointed president by the government; he has a second deciding vote in case of a tied vote.

A Medical Grant Stabilization Fund was established in the provincial Department of Finance to assist in stabilizing premiums, to ease the effect of cost-of-living changes on premiums, and to minimize the effect of the medical costs of high-cost illness on the premium structure. The government will pay one million dollars annually into the fund.

The Ontario Medical Services Insurance Act.

The Ontario Medical Services Insurance Act was passed in June 1965; the plan it established is due to commence on July 1, 1966. The main purposes of the plan are, first, to regulate the medical care insurance industry in Ontario by setting maximum premiums, benefit levels, and conditions of coverage, and second, subsidize the purchase of medical insurance by persons having little or no taxable income.

Eligibility and Coverage:

The plan will make a standard medical insurance contract available to all who purchase it, or who simply apply for it if they have no taxable income, regardless of age or health condition. This contract may be purchased from any of the licensed insurance carriers in the province, except those exempt from selling the standard contract. The Ontario government will be the carrier for all subsidized contracts.

Standard contracts must be guaranteed renewable and non-cancellable except in the case of non-payment of premium, fraud, or misuse of covered services. Standard contracts must cover a person who takes up residence outside the province for 90 days after he departs. They must provide either first dollar coverage, or co-insurance coverage with a $25 deductible ($50 maximum for a family) and payment, by the patient, of 20 per cent of medical costs. Family contracts will cover children up to and including the age of 20.

Waiting Periods:

Open enrolment periods will be held, during which anyone can purchase medical insurance. Insurance so purchased will become effective at the beginning of the first month following the end of the open enrolment period.

In addition, persons who achieve independent or resident status after the close of an open enrolment period will also be insured from the start of the month following application for medical insurance, if they apply within 30 days of attaining such status. The Ontario legislation also provides that a person may continue his medical insurance coverage should his group coverage expire during a time when there is no open enrolment, as long as he applies for continuation within 30 days of the expiration. Persons who apply more than 30 days after becoming eligible but not during an open enrolment period may purchase standard medical insurance but it does not become effective until three months after the date of application and payment.

There is an eight-month waiting period in any standard medical insurance contract for benefits in connection with pregnancy.

Benefits:

The standard medical insurance contract will provide to the covered person all necessary medical, surgical, and obstetrical services in the home, office, and hospital with the following limitations and exclusions. There will be limitations on annual health examinations, well-baby care, psychotherapy, and payment for specialists' services (see "Payment of Doctors", below). Among exclusions under the plan are services to which a person is entitled under other legislation, dental care for dental purposes, nursing and ambulance services, drugs, physical therapy, examination of the eyes by refraction, eyeglasses, and cosmetic surgery and services.

Premiums:

The government will set maximum premium levels for single persons, for families of two, and for families of three or more.

The maximum premium levels will be maintained for two years after the plan commences. Following that the maximum levels may be raised, but not more than once in any 12-month period.

An individual carrier may adjust its premium rates, on a class-risk basis only, (i.e., for all the insured persons in a particular class) once in every 12-month period, as long as the maximum rates are not exceeded.

A person who is unable to continue premium payments because of lack of income due to unemployment, illness, or disability, may apply to the administering council for assistance to continue his medical insurance payments while his income is interrupted.

Subsidies:

The Ontario government has stated its intention of paying subsidies to cover the entire premium of persons with no taxable income who apply for medical insurance. It will subsidize part of the premium of individuals with taxable income of $1 to $500, of married couples with taxable income of $1 to $1,000, and of families of three or more with taxable income of $1 to approximately $1,200. The proportion of the subsidy will vary inversely with a person's taxable income

until the cutoff level is reached, which is to say that persons with taxable incomes that are lower will receive subsidies that are higher. The government intends to provide public assistance recipients with standard medical insurance contracts.

Only first-dollar coverage contracts will be eligible for the subsidies. The Ontario government, through the newly-created Medical Services Insurance Division of the Department of Health, will be the sole carrier for all the medical-insurance contracts. The government estimates that some 1,800,000 persons, 27 per cent of the population, will qualify for the subsidies.

Payment of Doctors:

Doctors will be paid the fees listed in the Ontario Medical Association's fee schedule in effect on the day the plan begins. This fee schedule will continue to be used for the following two years.

The standard contract will pay for insured services at general practitioner rates, and at specialist rates when the patient is referred to a certified specialist by another physician or when there is no general practitioner fee listed in the Ontario Medical Association's schedule of fees.

Administration:

The Ontario Minister of Health is responsible for administering the Medical Services Insurance Act.

A Medical Services Insurance Council is established to advise the Minister on the administration of the plan as regards maximum premium rates, open enrolment periods, the general form and content of standard contracts, and other matters. The Council will deal with the complaints of the various parties involved in the plan. It will be composed of nine members, five representative of the public, two nominated by the Ontario Medical Association, and two nominated by the Corporation representing the licensed insurance carriers.

Medical Carriers Incorporated is established to administer the pooling of standard contracts, to collect statistics relative to standard contracts, and to exempt some licensed carriers from pooling requirements, in addition to other functions. All licensed carriers must belong to the Corporation. The Corporation's board of directors is to be composed of two appointees of the Canadian Health Insurance Association, two appointees of the physician-sponsored carriers, one of health insurance co-operatives, one of self-insurers and all other carriers, and a seventh appointed by the other six.

A new Medical Services Insurance Division is established in the Department of Health, to act as a carrier for all subsidized contracts. The Division is exempt from pooling arrangements and membership in the Corporation.

Insurance companies wishing to sell medical insurance in Ontario must become licensed carriers. Licences are issued by the Superintendent of Insurance, who must abide by the decision of the Medical Services Insurance Council when a refusal to grant a licence is appealed to the Council. Licensed carriers must offer for sale standard medical services insurance providing first-dollar coverage, unless exempted by the Minister of Health.

Public assistance personal health care programs. -

For several years Nova Scotia, Ontario, Saskatchewan, Alberta, British Columbia, and Manitoba, have supported the cost of providing certain personal health care services for specified categories of persons in need and receiving public assistance. In British Columbia and Ontario the beneficiaries include recipients of needs-tested or means-tested old age security, old age assistance, blindness and disability allowances, and mothers' allowances, certain child welfare cases, and unemployed persons in need (unemployables only in British Columbia). Dependents are also generally enrolled. Alberta covers similar categories of persons now qualifying under a provincial needs test.

Nova Scotia's program covers only mothers' allowance recipients and their dependents, and blindness allowance recipients. Saskatchewan's special provincial program enrols recipients of supplemental allowance to either old age security pensions or blindness allowances, aid to dependent families, and provincial short-term assistance. Old age assistance recipients are enrolled by the province, for hospital care and medical care benefits only, through the provincial health insurance programs. The Manitoba program covers aged and infirm persons requiring custodial care, recipients of blind persons' allowances, recipients of mothers' allowances and their dependents, and child wards. In all provinces, indigent persons not covered by these programs may have necessary care financed in the municipalities in which they reside.

Under the Ontario program, the principal service covered is physicians' care in the home and office, including certain out-of-hospital minor surgical procedures and prenatal and postnatal care. Basic dental care is available to the children of mothers' allowance recipients. The programs in Nova

Scotia, Saskatchewan, Alberta, British Columbia, and Manitoba provide for complete medical care in the home, office, and hospital. In addition, all generally-used prescription drugs are included in British Columbia, Manitoba, and Saskatchewan (although these carry a 50 per cent co-charge limitation in Saskatchewan for non-life-saving drugs where financial hardship is not demonstrated). Dental care and optical care are covered in the four westernmost provinces, sometimes only on special authorization and/or with dollar limits. Other services that may be provided in some provinces include diagnostic tests, appliances, physiotherapy, chiropody, chiropractic treatment, home nursing, and transportation for medical reasons.

In Alberta, Saskatchewan, Manitoba, and Nova Scotia, where provincial welfare recipients only are covered, health services for eligible persons are wholly financed from provincial general revenues. In British Columbia costs are shared on a 90-10 basis, with the municipalities assuming their 10 per cent share on a basis proportionate to population; in Ontario per capita contributions toward the cost of medical services for unemployed on relief are shared on an 80-20 basis with the municipality of residence.

Subsection 4 - Services for the Disabled and Chronically Ill

The success of rehabilitation programs for injured workers, war veterans, handicapped children, and other disability groups has encouraged more recent efforts to extend rehabilitation services to all handicapped persons. By 1964, physical medicine and rehabilitation departments were established in some 66 hospitals including 13 children's hospitals as well as in 6 veterans' hospitals. Complementing these were 48 independent rehabilitation centres including 27 children's centres and four workmen's compensation centres. Hospital services available to in-patients and out-patients include physical medicine, physiotherapy, occupational therapy, and social services; most of the children's hospitals and the teaching hospitals also supply speech therapy. The rehabilitation centres provide comprehensive medical, psychosocial, and vocational services to more severely disabled persons who require intensive or long-term therapy. In addition, the children's hospitals and centres operate special education classes. Community agencies such as those providing vocational rehabilitation services or home care co-operate in the rehabilitation of disabled children and adults.

Most large general hospitals conduct special out-patient clinics for various disabilities such as arthritis and rheumatism, diabetes, glaucoma, speech and hearing defects, heart

diseases, orthopedic conditions, and neurological conditions. The voluntary agencies that are concerned with specific disability groups, for example arthritics; the blind; the deaf; children suffering from cystic fibrosis, haemophilia, or muscular dystrophy; and the mentally ill or retarded; or with disabled persons generally, are also broadening their rehabilitation services. These agencies usually provide patient services, including the supply of personal aids and appliances, employment, and education services, operate sheltered workshops, and participate in the provision of services for the homebound. Other voluntary agencies operate sheltered workshops serving handicapped persons; over 100 were established by 1964.

An increased awareness of the value of home health services to the disabled, the chronically ill, and the aged has led many communities to extend home nursing, homemaker, physiotherapy, and other services to patients in their own homes. Organized home care programs under hospital or community sponsorship have been organized in the principal cities. The Victorian Order of Nurses has taken a leading role in these projects, while several provincial health departments have instituted home nursing services to residents of outlying districts.

Both the provincial health departments and the voluntary societies for crippled children are developing their service programs for the treatment and rehabilitation of physically and mentally handicapped children. Most of these agencies have established registries of handicapped children, of varying coverage, in co-operation with physicians, health units, voluntary societies, hospitals, and other agencies. Such registries, which are increasingly useful sources of morbidity statistics including statistics of congenital anomalies, assist in the planning and co-ordination of rehabilitation services. As well as medical rehabilitation, the handicapped-children's programs usually include family counselling, recreation, transportation, and foster home care; periodic travelling clinics extend diagnostic and treatment services to outlying areas. Special schools and classes for various groups of handicapped children are established by the local school boards in the main cities, while most of the nine residential schools for the deaf and the six for the blind are operated by the provincial education departments.

The establishment of three regional prosthetic research and training units in rehabilitation centres in Montreal, Toronto, and Winnipeg, supported by National Health Grants amounting to $200,000 a year, is a significant development.

These centres and several juvenile amputee clinics in other cities are rehabilitating children with limb deformities or amputations. A federal-provincial program, supported by National Health and National Welfare Grants, assists in the extraordinary rehabilitation, maintenance, and counselling costs on behalf of children with thalidomide-induced defects.

Services for the disabled and chronically ill are hampered by a shortage of qualified personnel, especially in the para-medical field. Helping to solve this shortage are the eight university schools offering training in physical therapy and/or occupational therapy and the three providing training in audiology and speech therapy. The Department of National Health and Welfare assists the provinces in their rehabilitation programs through the National Health Grants, especially the Medical Rehabilitation and Crippled Children Grant of $2,885,000 (1965-66). These grants are used to develop medical rehabilitation services and facilities, to support the training of medical rehabilitation personnel through grants to the university schools and student bursaries, and for equipment and research.

Section 4 - International Health

Canada actively assists and co-operates with the World Health Organization and the other specialized agencies of the United Nations whose programs have a substantial health component or orientation. Capital and technical assistance in the health field are provided to developing countries through the Colombo Plan and other bilateral aid programs. Health training is provided for a number of persons coming to Canada each year under the different technical co-operation schemes; during 1964, 64 trainees arrived, bringing the total number of trainees in Canada during the year to 212. These persons were working in a wide range of health disciplines under the External Aid Program.

Canadian experts in health legislation, health administration, and related areas undertook specific assignments abroad during the year, and specialists in a number of clinical fields were provided in response to requests from the developing countries. Capital assistance, primarily through the provision of cobalt beam therapy units for cancer treatment centres in the Colombo Plan area, was continued.

At the Sixteenth World Health Assembly in May 1962, Canada was elected to name a person to serve for a three-year term on the Executive Board of the World Health Organization and in 1963 this officer was appointed Chairman of the Board.

Canada's term of office on the Executive Board of UNICEF was renewed at the beginning of 1965 and similarly extends over a three-year period.

To carry out Canada's obligations under the International Sanitary Conventions, the Department of National Health and Welfare maintains quarantine measures for ships and aircraft entering Canadian ports and provides accommodation and necessary medical care for persons arriving in Canada who require quarantine (see p. 9).

The Department is responsible for the enforcement of requirements governing the handling and shipping of shellfish under the International Shellfish Agreement between Canada and the United States and, at the request of the International Joint Commission, participates in studies connected with control of pollution of boundary waters between Canada and the United States as well as with problems caused by atmospheric pollution. Other international health responsibilities include the custody and distribution of biological, vitamin, and hormone standards for the World Health Organization and certain duties in connection with the Single Convention on Narcotic Drugs - 1961, and Canada's representation on the Narcotic Commission of the United Nations.

PART II - PUBLIC WELFARE AND SOCIAL SECURITY

Responsibility for social welfare is shared by all levels of government. Comprehensive income-maintenance measures such as the Canada Pension Plan, old age security pensions, family allowances, and programs such as unemployment insurance and the National Employment Service where nationwide co-ordination is required, are administered federally. Substantial federal aid is given to the provinces in meeting the costs of public assistance. The federal government also provides services for special groups such as veterans, Indians, Eskimos, and immigrants.

The Department of National Health and Welfare is generally responsible for federal welfare matters; the Departments of Veterans Affairs, Citizenship and Immigration, and Northern Affairs and National Resources also operate programs for specific groups. The Unemployment Insurance Commission is responsible for the operation of unemployment insurance. The National Employment Service is administered by the Department of Labour.

Administration of welfare services is primarily the responsibility of the provinces but the provision of services is often assumed by local authorities, generally with financial aid from the province.

Co-ordination in welfare matters between different levels of government and between government and voluntary authorities will be facilitated by the newly established National Council of Welfare, an advisory body to the Minister of National Health and Welfare. The Council consists of the federal Deputy Minister of Welfare who acts as chairman, the provincial deputy ministers of welfare, and ten other persons appointed for three-year terms by the Governor in Council. The National Council of Welfare held its first meeting in Ottawa during April 1965.

Section 1 - Federal Welfare Programs

Subsection 1 - Canada Pension Plan

Canada Pension Plan legislation, enacted in 1965, provides an important new component in Canada's social security system. The plan is designed to provide, for most members of the labour force, a social insurance system whereby each contributor builds up a right to a graduated retirement pension the

amount of which is related to his previous earnings pattern. The plan also provides benefits to the disabled contributor and his dependent children and, at the contributor's death, a death benefit and benefits for his widow and orphaned children.

Retirement pensions under the Canada Pension Plan will come into effect according to the following staging. In 1967 contributors age 68 and over will be able to claim retirement pensions; contributors age 67 and over can do so in 1968, contributors age 66 and over in 1969, and contributors age 65 and over in 1970 and after.

Until the plan is 10 years old the rates of retirement pension will be built up steadily. In 1967, after one year of contributions, the retirement pension will be 2.5 per cent of a contributor's pensionable earnings. For anyone contributing for two years and retiring at age 67 or over in 1968, the pension will be 5 per cent of his earnings, and so on, until the full benefit of 25 per cent of pensionable earnings is first reached after 10 years of contributions.

Pensions for widows and disabled widowers, orphan's benefits, and the death benefit will first be payable early in 1968. Pensions for disabled contributors and for their dependent children will first be payable in the spring of 1970.

Coverage under the Canada Pension Plan and the comparable Quebec scheme will be comprehensive. For administrative and constitutional reasons there will be certain exemptions from coverage. Employees who earn $600 or less in a year and self-employed persons who earn less than $800 in a year will not pay contributions for that year.

The Canada Pension Plan will be financed by contributions based on earnings. The first $600 of each person's annual earnings will be exempt from contributions. On earnings above that amount, and below the ceiling, initially $5,000 a year, the employee will make a contribution of 1.8 per cent. Employers will make a matching contribution. Self-employed people will pay the combined rate of 3.6 per cent on annual earnings between $600 and $5,000 provided their total annual earnings are $800 or more.

The contributory limits under the Canada Pension Plan will be adjusted with changing economic conditions. For the first two years of the plan the upper and lower limits are $5,000 and $600. For the next eight years these limits will be adjusted by means of a specially constructed Pension Index, which reflects changes in the Consumer Price Index. After the tenth year, the contributory limits will be adjusted according to changes in

the Earnings Index, which will be based on a long-term average of national wages and salaries. For purposes of calculating a contributor's pension, his earnings record for each year will be adjusted at the time the benefit begins so that it bears the same relation to the contributory earnings upper limit in force at that time that his actual earnings bore to the upper limit prevailing in the year in which they were made.

In the calculation of a retirement pension, the contributor's earnings are averaged over the period from his age 18, or January 1966 if that is later, to his age 65 or until he claims a pension, if that is later. For each year beyond age 65 that a man continues to work and make contributions he will be able to exclude, after 1975, an additional low year. In order not to unduly penalize people whose earnings in some years are abnormally low through sickness or unemployment, the plan allows them to exclude, in calculating their average earnings, periods equal to 15 per cent of their remaining contributory periods. Earnings must, however, be averaged over at least 10 years.

The earnings-related retirement pension is designed for contributors who have retired from regular employment. If people continue to work or take up new employment after claiming a Canada retirement pension, they will have to pass a retirement test. The retirement test will be effective from age 65 until age 70 at which time the retirement pension will become payable unconditionally. The retirement test is such that when earnings exceed $900 a year, but not $1,500, the pension for that year will be reduced by one-half the excess. When earnings exceed $1,500 a year, pensions will be reduced by $300 plus earnings in excess of $1,500. In no case, however, will an adjustment be made to a pension for any month in which the pensioner's earnings do not exceed $75 no matter what his earnings in any other month may be. Retirement test limits will be adjusted in future in the light of changing economic conditions.

A contributor who becomes disabled after making the required number of contributions will be entitled to a disability pension. This pension consists of a flat rate component, initially $25 monthly, and an earnings-related component amounting to 75 per cent of the retirement pension otherwise payable to the disabled contributor. In calculating this retirement pension, earnings are averaged over the period from age 18 or January 1966 until the date the disability pension becomes payable - the minimum period being 60 months.

In addition to the disability pension, benefits will be payable for dependent children of a disability pensioner. These will be dependent children under age 18 and children up to age 25 if in full-time attendance at school. The rate of benefit is $25 for each of the first four eligible children and $12.50 for each additional child.

A widow age 45 or over at the contributor's death, a disabled widow of any age, and a widow of any age with dependent children will be entitled to a widow's pension consisting of a flat rate component, initially $25 a month, and an earnings related component equal to 37.5 per cent of the retirement pension payable to her deceased husband. A widow who is not disabled and who is not caring for dependent children will have her pension reduced if she is under age 45 at the death of her husband; if she is under age 35, no pension is payable until she is 65. Since these widow's pensions include a flat rate component, a minimum number of contributions by the deceased contributor are required.

In addition to widow's pensions, benefits will be available for orphans. These are equal in amount to the benefits provided to dependent children of a disability pensioner.

Women widowed at age 65 or more and widows reaching age 65 will receive pensions of 60 per cent of their husbands' retirement pensions. Many widows age 65 or more will also be entitled to retirement pensions of their own. At age 65 there are provided two alternative formulae for the re-calculation of the widow's pension thereby providing retirement income which would best reflect the widow's particular circumstances.

A pension is also provided for the disabled widower if he was disabled at the time of his wife's death and was wholly or substantially maintained by her. The pension for a disabled widower less than 65 years of age is $25 plus 37.5 per cent of his wife's retirement pension. For a disabled widower reaching age 65 or for a person becoming a disabled widower after age 65, the rate of pension is 60 per cent of his wife's retirement pension. Disabled widowers entitled to their own retirement pensions are provided with two alternative formulae for purposes of calculating their total retirement income. The disabled widower must continue to prove disability for the duration of his pension.

A lump sum death benefit is payable subject to the same qualifying conditions as pertain to other survivors' pensions. The amount of the benefit is six times the monthly retirement benefit that is being (or would be) paid to the contributor in the month of his death, but cannot exceed 10 per cent of the contributory ceiling for that year.

Canada Pension Plan benefits, once they have commenced to be paid, will be adjusted in accordance with changes in the Pension Index.

The Department of National Health and Welfare will administer the Canada Pension Plan. Contributions will be collected by the Department of National Revenue commencing January 1, 1966. Employers will be responsible for deductions from their employees' earnings and for remitting these, along with their own contributions, to the Department of National Revenue. Self-employed persons will make payments directly at the time such people normally pay their income tax. The administration of the federal legislation will be co-ordinated with provincial legislation of a comparable nature.

Social insurance numbers, which have already been issued to over six million people, will be extended to all contributors under the Canada Pension Plan.

Appeals in connection with coverage and contributions may be made to the Minister of National Revenue. If a contributor is not satisfied, he may appeal further to the Pension Appeals Board whose decision is final except when any question of fact or law involves the operation of the act in a province providing its own comprehensive pension plan. In this case a further appeal may be made to the Supreme Court of Canada.

With regard to benefits there is a three-stage appeal procedure. First, an appeal may be directed to the Minister of National Health and Welfare. An applicant who is not satisfied with the Minister's decision may appeal to a Review Committee. The third level of appeal is to the Pension Appeals Board whose decision is final and binding.

The legislation provides authority for reciprocal agreements with other countries where there is a common interest in the portability of pensions, and where a mutually satisfactory agreement can be attained.

Subsection 2 - Old Age Security

Under the Old Age Security Act of 1951, as amended, a universal pension of $75 a month is payable by the federal government to all persons who meet the residence and age qualifications. The Old Age Security pension of $75 a month is payable in 1965 to those age 70 and over. It will be payable in 1966 to people age 69 and over. In 1967 people

age 68 will become eligible and so on, until by 1970 $75 a month will be payable to anyone age 65 or more who meets the residence test.

In 1968 and succeeding years the amount of the Old Age Security pension will be increased in line with changes in the Pension Index developed for the Canada Pension Plan.

The Old Age Security pension is payable to a person who has attained the qualifying age and who has resided in Canada for ten years immediately preceding his application for the pension. If there have been gaps in the ten year period, these gaps may be offset if the applicant has been present in Canada in earlier years for periods of time which are equal in total to double the length of the gaps. In this case, however, the applicant must also have resided in Canada for one year immediately before his application for pension.

Under a new amendment, persons who have had 40 years of residence in Canada since age 18 will become eligible for the Old Age Security pension provided they meet the minimum age requirement. This will be helpful to many persons who have left Canada before reaching the qualifying age but who have spent virtually all of their working lives in Canada.

After application for pension has been approved, a pensioner may absent himself from Canada and continue to receive pension payments. If he has lived in Canada for twenty-five years since his twenty-first birthday, payment of his pension outside of Canada may continue indefinitely. If he has not so resided, payment is continued for six months, in addition to the month of departure, and is then suspended, to be resumed only with the month in which he returns to Canada.

The program is administered by the Department of National Health and Welfare through regional offices in each provincial capital.

The pension is financed on the pay-as-you-go method through a 3 per cent sales tax, a 3 per cent tax on corporation income, and, subject to a limit of $120 a year, a 4 per cent tax on taxable personal income. Yields from these taxes are paid into the Old Age Security Fund; if they are insufficient to meet the pension payments, temporary loans are made from the Consolidated Revenue Fund. Operations of the Old Age Security Fund for the fiscal years ended March 31, 1960 to 1965 are shown in Table 13, and province-by-province statistics of pensioners and pension-payments appear in Table 14.

TABLE 13 - OPERATION OF THE OLD AGE SECURITY FUND, YEARS ENDED MARCH 31, 1960 TO 1965

Item	1959-60	1960-61	1961-62	1962-63	1963-64	1964-65
	$	$	$	$	$	$
Source of funds:						
Sales tax	270,000,055	270,231,478	284,879,239	302,238,927	331,760,067	383,151,254
Corporation income tax	91,336,000	103,500,000	100,125,000	115,250,000	115,750,000	145,250,000
Individual income tax	185,550,000	229,400,000	258,950,000	273,650,000	302,600,000	431,900,000
Loan from consolidated revenue fund	28,000,991	-	-	41,679,066	58,281,233	-
Balance brought forward	-	-	-	1,563,639	-	-
Total	574,887,046	603,131,478	643,954,239	734,381,632	808,391,300	960,301,254
Application of funds:						
Benefit payments	574,887,046	592,413,283	625,107,804	734,381,632	808,391,300	885,294,468
Repayment of loans to consolidated revenue fund	-	10,718,195	17,282,796	-	-	75,006,786
Balance carried over	-	-	1,563,639	-	-	-
Total	574,887,046	603,131,478	643,954,239	734,381,632	808,391,300	960,301,254

TABLE 14 - OLD AGE SECURITY STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965

Province and year	Pensioners in March	Net pensions paid during fiscal year	Province and year	Pensioners in March	Net pensions paid during fiscal year
	No.	$		No.	$
Newfoundland... 1962	17,801	11,947,626	Manitoba..... 1962	56,567	38,085,361
1963	18,184	14,013,832	1963	57,692	44,617,405
1964	18,477	15,376,636	1964	58,850	48,874,928
1965	18,886	16,811,166	1965	59,818	53,360,235
Prince Edward					
Island..... 1962	7,603	5,151,999	Saskatchewan..... 1962	58,436	39,621,029
1963	7,635	5,962,922	1963	59,690	46,334,646
1964	7,792	6,493,258	1964	60,587	50,751,907
1965	7,949	7,118,615	1965	61,257	55,063,268
			Alberta..... 1962	62,658	42,276,129
Nova Scotia.... 1962	42,572	28,895,584	1963	64,286	49,787,140
1963	43,583	33,817,492	1964	65,746	54,835,096
1964	44,424	37,063,710	1965	67,245	60,052,938
1965	45,014	40,399,804			
			British Columbia... 1962	117,815	79,622,315
New Brunswick.. 1962	31,316	21,291,111	1963	120,678	93,362,860
1963	31,935	24,858,331	1964	122,732	102,639,328
1964	32,592	27,247,749	1965	124,262	111,327,361
1965	33,262	29,780,719			
			Yukon and North-		
Quebec..... 1962	196,827	131,711,372	West Territories.. 1962	656	439,865
1963	202,405	155,359,915	1963	676	524,445
1964	207,917	171,996,794	1964	680	564,696
1965	214,294	189,682,327	1965	707	633,415
Ontario..... 1962	335,339	226,065,413	Canada..... 1962	927,590	625,107,804
1963	344,002	265,742,644	1963	950,766	734,381,632
1964	352,004	292,547,198	1964	971,801	808,391,300
1965	360,888	321,064,620	1965	993,582	885,294,468

Persons in receipt of old age assistance who reach the eligible age are automatically transferred to old age security. Others make application to the regional offices. Recipients of old age security who are in need may receive supplementary aid under general assistance programs in the provinces. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

Subsection 3 - Family Allowances

The Family Allowances Act of 1944 is designed to assist in providing equal opportunities for all Canadian children. The allowances do not involve a means test and are paid from the federal Consolidated Revenue Fund. They do not constitute taxable income but there is a smaller income tax exemption for children eligible for allowances.

Allowances are payable in respect of every child under the age of 16 years who was born in Canada, or who has been a resident of the country for one year, or whose father or mother was domiciled in Canada for three years immediately prior to the birth of the child. Payment is made by cheque each month, normally to the mother, although any person who substantially maintains the child may be paid the allowance on his behalf. Allowances are paid at the monthly rate of $6 for each child under 10 years of age and $8 for each child aged 10 or over but under 16 years. If the allowances are not spent for the purposes outlined in the Act, payment may be discontinued or made to some other person or agency on behalf of the child. Allowances are not payable for any child who fails to comply with provincial school regulations or on behalf of a girl who is married and under 16 years of age. The program is administered by the Department of National Health and Welfare through regional offices located in each provincial capital. A Regional Director for the Yukon and Northwest Territories is located at Edmonton.

The Federal Government pays family assistance, at the rates applicable for family allowances, for each child under 16 years of age resident in Canada and supported by an immigrant who has landed for permanent residence in Canada, or by a Canadian returned to Canada to reside permanently. The assistance, which is payable monthly and for maximum period of one year, is not payable for a child eligible for family allowances.

TABLE 15 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965

Province and year		Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(1)		Net total allowances paid during fiscal year
					Per family	Per child	
		No.	No.	No.	$	$	$
Newfoundland.....	1962	65,705	204,855	3.12	20.87	6.69	16,336,849
	1963	66,657	207,120	3.11	20.80	6.70	16,562,083
	1964	67,635	209,180	3.09	20.75	6.71	16,747,021
	1965	68,418	210,016	3.07	20.59	6.71	16,871,056
Prince Edward Island..	1962	14,190	39,931	2.81	18.98	6.74	3,204,881
	1963	14,344	40,423	2.82	18.99	6.74	3,259,952
	1964	14,377	40,524	2.82	19.05	6.76	3,274,057
	1965	14,191	40,201	2.83	19.12	6.75	3,266,459
Nova Scotia.....	1962	105,868	271,036	2.56	17.14	6.70	21,623,655
	1963	106,018	271,476	2.56	17.14	6.69	21,838,772
	1964	105,754	271,336	2.57	17.20	6.70	21,790,680
	1965	105,163	269,845	2.57	17.24	6.72	21,776,091
New Brunswick.....	1962	83,014	239,340	2.88	19.41	6.73	19,222,615
	1963	83,272	239,507	2.87	19.33	6.72	19,340,514
	1964	82,711	237,093	2.87	19.29	6.73	19,198,184
	1965	82,578	235,714	2.85	19.24	6.74	19,069,036
Quebec.....	1962	739,126	1,976,677	2.67	17.96	6.71	157,712,911
	1963	752,413	1,999,894	2.66	17.87	6.72	160,299,079
	1964	766,364	2,017,190	2.63	17.74	6.74	162,172,423
	1965	780,305	2,037,605	2.61	17.60	6.74	163,888,091
Ontario.....	1962	929,461	2,133,116	2.29	15.32	6.68	168,442,100
	1963	939,314	2,172,643	2.31	15.44	6.68	172,711,354
	1964	949,955	2,209,982	2.33	15.56	6.69	175,544,729
	1965	964,468	2,248,642	2.33	15.65	6.71	179,056,316
Manitoba.....	1962	132,338	315,238	2.38	15.94	6.69	25,065,334
	1963	132,937	319,564	2.40	16.07	6.69	25,523,719
	1964	133,105	321,413	2.41	16.17	6.69	25,727,440
	1965	133,500	323,862	2.43	16.24	6.69	25,926,570

(1) Based on gross payment for March.

TABLE 15 - FAMILY ALLOWANCES STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965 (Concluded)

Province and year		Families receiving allowance in March	Children for whom allowance paid in March	Average number of children per family in March	Average allowance(1)		Net total allowances paid during fiscal year
					Per family	Per child	
		No.	No.	No.	$	$	$
Saskatchewan.....	1962	131,975	329,681	2.50	16.70	6.69	26,313,109
	1963	131,066	331,394	2.53	16.89	6.68	26,539,801
	1964	131,240	333,051	2.53	16.97	6.69	26,650,259
	1965	131,449	335,381	2.55	17.09	6.70	26,891,288
Alberta.....	1962	204,698	496,712	2.43	16.13	6.65	38,928,125
	1963	208,646	509,805	2.44	16.29	6.67	40,315,733
	1964	211,105	519,140	2.46	16.47	6.70	41,227,721
	1965	212,630	525,976	2.47	16.57	6.70	41,996,327
British Columbia.....	1962	236,646	538,934	2.28	15.24	6.69	42,687,279
	1963	239,496	550,380	2.30	15.40	6.70	43,834,184
	1964	242,789	561,174	2.31	15.51	6.71	44,712,129
	1965	247,635	573,714	2.32	15.58	6.73	45,745,199
Yukon and Northwest Territories.....	1962	6,296	16,767	2.66	17.04	6.40	1,244,335
	1963	6,582	17,674	2.68	17.03	6.34	1,341,158
	1964	6,237	16,074	2.58	17.21	6.68	1,267,581
	1965	6,212	16,057	2.58	17.19	6.65	1,288,798
Canada.....	1962	2,649,317	6,562,287	2.48	16.58	6.69	520,781,193
	1963	2,680,745	6,659,880	2.48	16.63	6.69	531,566,349
	1964	2,711,272	6,736,157	2.48	16.67	6.71	538,312,224
	1965	2,746,549	6,817,013	2.48	16.68	6.72	545,775,231

(1) Based on gross payment for March.

Subsection 4 - Youth Allowances

Legislation providing for a program of youth allowances was assented to on July 16, 1964 and became effective September 1964. The federal government does not provide youth allowances in Quebec, which has its own program, but compensates that province by an amount equal to what the federal government would otherwise have paid in allowances to Quebec residents.

Under the federal program, monthly allowances of $10 are payable in respect of all dependent youths age 16 and 17 who are receiving full-time educational training or are precluded from doing so by reason of physical or mental infirmity. Both the parent or guardian and the youth must normally be physically present and living in a province other than Quebec. The allowance is not payable to a parent who does not reside in Canada outside Quebec, even though his child may be attending school there. On the other hand, a dependent youth may attend school in Quebec or outside Canada or, if disabled, receive care or training in Quebec or outside Canada, and still be considered eligible, on the basis that he is a resident of one of the nine provinces but is temporarily absent.

Allowances normally commence with the month following that in which family allowances cease and continue until the school year terminates. They are paid retroactively for the summer months on the commencement of the new school year. Allowances for a disabled child not attending school, however, are payable continuously throughout the year. Should the youth leave school, leave the country permanently, cease to be maintained, take up residence in Quebec, or die, the allowance will cease. Otherwise, the youth allowance continues until the end of the month in which the youth reaches age 18.

Youth allowances are considered not to be income for any purpose of the Income Tax Act.

The program is administered by the federal government through the Department of National Health and Welfare. The national director of the family allowances and old age security programs also administers youth allowances. He is assisted by regional directors located in each of the provincial capitals.

The costs of youth allowances are met from the Consolidated Revenue Fund. For the seven months ended March 31, 1965, the cost of youth allowances was estimated to be

$27,000,000. For the first full year of the program, that is the fiscal year ending March 31, 1966, it is estimated that the cost of allowances will amount to $48,000,000. Additional funds will, of course, be expended in the form of compensation to the province of Quebec. At the end of March 1965 youth allowances were being paid in respect of 398,037 children, excluding Quebec.

Section 2 - Federal-Provincial Welfare Programs

Subsection 1 - Canada Assistance Plan

Proposals for a Canada Assistance Plan that would complement the provisions of the Canada Pension Plan were announced in the Throne Speech on April 5, 1965 and were discussed at a Federal-Provincial Conference of Ministers of Welfare on April 8 and 9. Under the Plan, the federal government would be prepared to contribute, through comprehensive assistance programs adopted by the provinces, to the cost of assisting persons in need. Rates of assistance would be set by the provinces or their municipalities.

The plan would provide for the extension of federal sharing to the costs of assisting needy mothers and of providing health care services to assistance recipients. Federal sharing would also cover expenditures for public assistance administration, and for improving and extending welfare services for assistance recipients, in order to encourage the development of services that would enable assistance recipients to achieve the greatest possible degree of self support.

Subsection 2 - Old Age Assistance

The Old Age Assistance Act of 1951, as amended, provides for federal reimbursement to the provinces for assistance to persons aged 65 or over who are in need and who have resided in Canada for at least ten years or who, if absent from Canada during this period, have been present in Canada prior to the commencement of the ten-year period for double any period of absence during the ten years. A pensioner is transferred to old age security on reaching the age of eligibility for it. The federal contribution may not exceed 50 per cent of $75 a month or of the assistance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of assistance payable, the maximum income allowed, and other conditions of eligibility.

TABLE 16 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965

Province and year		Recipients in March	Average amount of monthly assistance	Recipients as percentage of population age 65-69	Federal government contribution during year[a]
		No.	$		$
Newfoundland	1962	5,184	52.42	52.90	1,672,510
	1963	5,187	63.00	52.93	1,987,213
	1964	5,081	62.79	51.32	1,945,021
	1965	5,088	72.41	51.39	2,220,908
Prince Edward Island	1962	897	49.07	24.92	248,608
	1963	1,037	60.35	28.81	375,350
	1964	1,130	60.38	32.29	394,947
	1965	1,229	70.43	35.11	508,587
Nova Scotia	1962	5,248	51.76	24.64	1,569,348
	1963	5,421	59.76	25.57	2,007,871
	1964	5,509	69.11	26.11	2,084,088
	1965	5,574	68.53	26.42	2,302,860
New Brunswick	1962	5,421	62.42	33.46	1,760,484
	1963	5,491	61.58	34.11	2,065,950
	1964	5,447	70.96	34.26	2,121,388
	1965	5,356	70.28	33.69	2,303,178
Quebec	1962	34,615	50.84	28.94	10,896,302
	1963	37,086	61.48	30.25	13,793,745
	1964	38,206	60.96	30.35	13,860,075
	1965	39,239	70.35	31.17	16,589,045
Ontario	1962	22,868	58.24	12.54	6,903,031
	1963	23,925	58.80	12.93	8,458,293
	1964	25,197	67.59	13.32	9,134,698
	1965	26,049	67.03	13.78	10,465,257
Manitoba	1962	5,082	62.11	18.09	1,652,229
	1963	5,448	60.83	19.39	2,001,606
	1964	5,436	70.06	19.35	2,105,940
	1965	5,520	69.15	19.64	2,329,362

(a) Maximum assistance sharable by the federal government was increased from $55 to $65 a month as of February 1962 and to $75 as of December 1963.

TABLE 16 - OLD AGE ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965 (Concluded)

Province and year	Recipients in March	Average amount of monthly assistance	Recipients as percentage of population age 65-69	Federal government contribution during year[a]
	No.	$		$
Saskatchewan..... 1962	5,760	50.47	20.79	1,761,661
1963	5,866	59.63	21.33	2,220,539
1964	5,549	68.59	20.33	2,151,490
1965	5,463	69.04	20.01	2,294,105
Alberta..... 1962	6,494	50.08	20.23	2,000,956
1963	6,479	60.30	19.81	2,523,720
1964	6,644	69.56	19.83	2,559,785
1965	6,810	69.00	20.33	2,901,039
British Columbia..... 1962	7,189	51.64	14.32	2,283,927
1963	7,039	62.26	14.05	2,675,207
1964	6,864	72.01	13.57	2,781,892
1965	6,829	71.82	13.50	2,991,013
Yukon Territory..... 1962	46	54.39	23.00	15,507
1963	34	64.47	17.00	15,287
1964	31	65.00	10.33	12,113
1965	31	75.00	10.33	13,880
Northwest Territories.. 1962	140	53.83	46.67	46,021
1963	144	63.36	48.00	54,275
1964	147	64.40	49.00	56,743
1965	166	74.32	55.33	71,721
Canada..... 1962	98,944	53.87	20.14	30,810,585
1963	103,159	60.68	20.74	38,179,057
1964	105,241	65.72	20.82	39,208,181
1965	107,354	69.43	21.24	44,990,955

(a) Maximum assistance sharable by the federal government was increased from $55 to $65 a month as of February 1962 and to $75 as of December 1963.

For an unmarried person, total income allowed, including assistance, may not exceed $1,260 a year. For a married couple it may not exceed $2,220 a year or, when the spouse is blind within the meaning of the Blind Persons Act, $2,580 a year. Assistance is not paid to a person receiving an old age security pension or an allowance under the Blind Persons Act, the Disabled Persons Act, or the War Veterans Allowance Act.

Recipients of old age assistance who are in need may receive supplementary aid under general assistance programs in the provinces. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

Subsection 3 - Allowances for Blind Persons

The Blind Persons Act of 1951, as amended, provides for federal reimbursement to the provinces for allowances to blind persons aged 18 or over who are in need and who have resided in Canada for at least ten years. The federal contribution may not exceed 75 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable and the maximum income allowed.

To qualify for an allowance a person must meet the required definition of blindness and have resided in Canada for ten years immediately preceding the commencement of the allowance or, if absent from Canada during this period, must have been present in Canada prior to its commencement for a period equal to double any period of absence during the period. For an unmarried person, total income including the allowance may not exceed $1,500 a year; for a person with no spouse with one or more dependent children, $1,980; for a married couple, $2,580. When the spouse is also blind, income of the couple may not exceed $2,700. Allowances are not payable to a person receiving assistance under the Old Age Assistance Act, an allowance under the Disabled Persons Act or the War Veterans Allowance Act, a pension under the Old Age Security Act, or a pension for blindness under the Pensions Act.

Recipients of blindness allowances who are in need may receive supplementary aid under general assistance programs in the provinces. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

TABLE 17 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965

Province and year	Recipients in March	Average amount of monthly allowance	Recipients as percentage of population age 20-69	Federal government contribution during year(a)
	No.	$		$
Newfoundland..... 1962	429	54.40	0.204	208,816
1963	429	63.70	0.200	247,377
1964	436	63.66	0.200	246,924
1965	460	73.49	0.211	300,474
Prince Edward Island.... 1962	80	63.13	0.157	40,168
1963	83	63.21	0.162	47,103
1964	79	64.43	0.155	46,778
1965	71	73.47	0.139	51,020
Nova Scotia..... 1962	771	63.74	0.205	386,325
1963	792	63.08	0.208	450,275
1964	775	73.00	0.203	468,866
1965	750	73.41	0.197	509,671
New Brunswick..... 1962	697	64.24	0.241	349,237
1963	701	63.79	0.241	410,317
1964	679	73.77	0.232	418,037
1965	679	74.10	0.232	456,965
Quebec..... 1962	2,901	53.59	0.104	1,412,002
1963	2,891	63.74	0.102	1,662,937
1964	2,855	63.65	0.098	1,642,869
1965	2,843	73.47	0.098	1,892,813
Ontario..... 1962	1,846	57.94	0.053	836,687
1963	1,877	58.73	0.053	992,300
1964	1,902	67.59	0.053	1,045,329
1965	1,906	67.93	0.053	1,179,138
Manitoba..... 1962	378	62.93	0.076	188,335
1963	379	68.80	0.075	214,163
1964	383	72.67	0.076	230,264
1965	401	72.66	0.079	258,946

(a) Maximum allowance sharable by the federal government was increased from $55 to $65 a month as of February 1962 and to $75 as of December 1963.

TABLE 17 - BLINDNESS ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Recipients as percentage of population age 20-69	Federal government contribution during year(a)
		No.	$		$
Saskatchewan.....	1962	406	53.03	0.085	193,308
	1963	422	63.18	0.089	240,693
	1964	406	71.51	0.085	246,010
	1965	391	72.02	0.082	256,063
Alberta.....	1962	454	53.17	0.063	222,545
	1963	463	63.53	0.063	271,516
	1964	465	72.65	0.063	278,014
	1965	475	72.36	0.064	311,992
British Columbia.....	1962	563	53.47	0.062	270,365
	1963	547	64.04	0.060	319,457
	1964	551	73.93	0.059	335,593
	1965	556	73.15	0.059	372,208
Yukon Territory.....	1962	3	55.00	0.036	1,485
	1963	4	65.00	0.049	2,239
	1964	4	65.00	0.047	1,999
	1965	5	75.00	0.059	2,666
Northwest Territories..	1962	45	52.11	0.372	20,580
	1963	46	59.13	0.393	23,452
	1964	46	64.14	0.387	27,214
	1965	49	74.39	0.412	32,746
Canada.....	1962	8,573	56.78	0.087	4,129,852
	1963	8,634	62.50	0.087	4,881,829
	1964	8,581	68.12	0.085	4,987,897
	1965	8,586	72.10	0.085	5,624,702

(a) Maximum allowance sharable by the federal government was increased from $55 to $65 a month as of February 1962 and to $75 as of December 1963.

Subsection 4 - Allowances for Disabled Persons

The Disabled Persons Act of 1954, as amended, provides for federal reimbursement to the provinces for allowances paid to permanently and totally disabled persons age 18 or over who are in need and who have resided in Canada for at least ten years immediately preceding commencement of allowance or, if absent from Canada during this period, have been present in Canada prior to its commencement for a period equal to double any period of absence during the period. To qualify for an allowance a person must meet the definition of "permanent and total disability" set out in the Regulations to the Act, which requires that a person must be suffering from a major physiological, anatomical, or psychological impairment, verified by objective medical findings; the impairment must be one that is likely to continue indefinitely without substantial improvement and that will severely limit activities of normal living. The federal contribution is 50 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable, the maximum income allowed, and other conditions of eligibility.

For an unmarried person, total income including the allowance may not exceed $1,260 a year. For a married couple the limit is $2,220 a year except that, if the spouse is blind within the meaning of the Blind Persons Act, income of the couple may not exceed $2,580 a year. Allowances are not paid to a person receiving an allowance under the Blind Persons Act or the War Veterans Allowance Act, assistance under the Old Age Assistance Act, a pension under the Old Age Security Act, or a mother's allowance.

The allowance is not payable to a patient in a mental institution or tuberculosis sanatorium. A recipient who is resident in a nursing home, an infirmary, a home for the aged, an institution for the care of incurables, or a private, charitable, or public institution is eligible for the allowance only if the major part of the cost of his accommodation is being paid by himself or another individual. When a recipient is required to enter a public or private hospital, the allowance may be paid for no more than two months of hospitalization in a calendar year, excluding months of admission and release, but for the period that a recipient is in hospital for therapeutic treatment for his disability or rehabilitation, the allowance may continue to be paid.

TABLE 18 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965

Province and year	Recipients in March	Average amount of monthly allowance	Recipients as percentage of population age 20-69	Federal government contribution during year(a)
	No.	$		$
Newfoundland..... 1962	1,292	54.51	0.616	413,676
1963	1,436	64.61	0.670	532,852
1964	1,586	64.53	0.726	587,092
1965	1,746	74.63	0.799	750,279
Prince Edward Island... 1962	780	64.44	1.529	258,995
1963	795	64.40	1.556	311,831
1964	801	64.47	1.574	310,817
1965	797	74.31	1.566	360,150
Nova Scotia..... 1962	2,776	64.02	0.737	908,644
1963	2,919	63.84	0.767	1,113,882
1964	3,108	73.79	0.815	1,229,805
1965	3,329	73.88	0.873	1,446,725
New Brunswick..... 1962	2,000	64.54	0.692	668,392
1963	2,060	64.51	0.707	791,069
1964	2,141	74.39	0.733	859,995
1965	2,263	74.36	0.775	987,471
Quebec..... 1962	22,528	54.09	0.806	7,460,933
1963	21,347	64.33	0.749	8,577,890
1964	20,753	64.29	0.714	8,081,258
1965	20,171	74.23	0.694	9,090,736
Ontario..... 1962	13,762	63.47	0.394	4,503,239
1963	14,886	63.69	0.423	5,537,215
1964	15,938	73.43	0.445	6,182,921
1965	17,222	73.23	0.481	7,378,219
Manitoba..... 1962	1,447	64.04	0.290	477,943
1963	1,520	64.19	0.301	577,685
1964	1,518	74.09	0.300	615,287
1965	1,538	73.96	0.304	679,916

(a) Maximum allowance sharable by the federal government was increased from $55 to $65 a month as of February 1962 and to $75 as of December 1963.

TABLE 18 - DISABLED PERSONS' ALLOWANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1962 TO 1965 (Concluded)

Province and year		Recipients in March	Average amount of monthly allowance	Recipients as percentage of population age 20-69	Federal government contribution during year(a)
		No.	$		$
Saskatchewan.....	1962	1,502	54.33	0.315	489,505
	1963	1,602	64.46	0.338	630,838
	1964	1,657	74.27	0.348	669,042
	1965	1,780	74.18	0.373	784,700
Alberta.....	1962	1,762	53.22	0.246	558,533
	1963	1,780	63.56	0.244	697,294
	1964	1,815	73.44	0.245	727,595
	1965	1,874	73.56	0.253	830,170
British Columbia.....	1962	2,156	54.02	0.239	685,428
	1963	2,248	64.18	0.245	853,602
	1964	2,319	74.04	0.247	929,723
	1965	2,336	73.94	0.249	1,037,484
Yukon Territory.....	1962	5	55.00	0.060	1,760
	1963	7	65.00	0.085	2,358
	1964	3	68.33	0.035	2,262
	1965	2	75.00	0.024	1,148
Northwest Territories..	1962	19	55.00	0.157	6,563
	1963	21	65.00	0.179	7,797
	1964	32	65.31	0.269	10,745
	1965	45	75.00	0.378	18,435
Canada.....	1962	50,029	58.07	0.509	16,433,611
	1963	50,621	64.10	0.509	19,634,313
	1964	51,671	69.48	0.511	20,206,543
	1965	53,103	73.86	0.525	23,365,493

(a) Maximum allowance sharable by the federal government was increased from $55 to $65 a month as of February 1962 and to $75 as of December 1963.

As in previous years, disabilities in the two medical classes-- mental, psychoneurotic and personality disorders, and diseases of the nervous system and sense organs -- have been found to be the most prevalent among the persons becoming eligible for allowance, followed by diseases of the circulatory system. Mental deficiency, the most frequently occurring disability, accounted for over one quarter of all cases granted an allowance.

Recipients of disability allowances who are in need may receive supplementary aid under general assistance programs in the province. Where the amount of aid is determined through an individual assessment of need, which takes the recipient's requirements and resources into consideration, the federal government may share in it under the Unemployment Assistance Act.

Subsection 5 - Unemployment Assistance

Under the Unemployment Assistance Act 1956, as amended, the federal government may enter an agreement with any province to reimburse it for 50 per cent of the unemployment assistance expenditures made by the province and its municipalities to persons and their dependents who are unemployed and in need. All provinces and the two territories have signed agreements under the Act. The rates and conditions of assistance are determined by the provinces and, in some cases, by their municipalities. Payments to both employable and unemployable persons in need are sharable under the agreements, as are the costs of maintaining persons in homes for special care, such as nursing homes or homes for the aged. The federal government shares in additional assistance paid to needy persons in receipt of old age security pensions, old age assistance, blind persons' allowances, disabled persons' allowances, and unemployment insurance benefits, where the amount of the assistance paid is determined through an assessment of the recipient's basic requirements and of his financial resources.

During the year ended March 31, 1964, the federal government made payments for unemployment assistance amounting to $107,370,707. The federal share of assistance costs shown in Table 17, however, is based on payments for the months in which the assistance was actually given and, since claims may be submitted at any time within six months after the month to which they relate, the figures for each fiscal year include certain reimbursements made to the provinces after the end of that year.

TABLE 19 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1961 TO 1964

Province and year		Recipients[1] in March	Federal share of unemployment assistance costs[2]
		No.	$
Newfoundland.....	1961	51,985(3)	3,413,393
	1962	59,144(3)	4,064,063
	1963	59,199(3)	4,218,132
	1964	59,090(3)	4,565,680
Prince Edward Island...	1961	2,395	155,748
	1962	2,819	174,422
	1963	3,270	261,242
	1964	2,924	292,832
Nova Scotia.....	1961	23,338(3)	1,853,784
	1962	26,200(3)	1,673,624
	1963	28,056(3)	1,630,551
	1964	27,565(3)	1,798,653
New Brunswick.....	1961	30,567(3)	1,494,980
	1962	33,841(3)	1,526,125
	1963	39,782(3)	1,715,372
	1964	31,114(3)	1,743,488
Quebec.....	1961	175,165	17,155,104
	1962	253,446	31,952,317
	1963	265,612	36,274,154
	1964	253,295	39,130,901
Ontario.....	1961	111,235	14,546,044
	1962	123,923	18,743,006
	1963	141,068(3)	20,447,510
	1964	140,066(3)	24,350,089
Manitoba.....	1961	27,113(3)	3,550,886
	1962	32,348(3)	4,285,123
	1963	32,579(3)	4,526,994
	1964	31,282(3)	4,952,050

TABLE 19 - UNEMPLOYMENT ASSISTANCE STATISTICS, BY PROVINCE, YEARS ENDED MARCH 31, 1961 TO 1964 (Concluded)

Province and year		Recipients(1) in March	Federal share of unemployment assistance costs(2)
		No.	$
Saskatchewan.....	1961	27,286	2,327,294
	1962	44,490(3)	4,535,334
	1963	44,227(3)	4,777,911
	1964	41,880(3)	4,614,614
Alberta.....	1961	26,388	2,917,607
	1962	35,136(3)	4,445,703
	1963	44,824(3)	6,486,669
	1964	51,048(3)	7,981,780
British Columbia.....	1961	86,702(3)	12,241,625
	1962	91,816(3)	15,965,424
	1963	94,570(3)	15,798,279
	1964	93,763(3)	16,918,569
Yukon Territory.....	1961	244	31,862
	1962	205	39,820
	1963	292	52,496
	1964	352	67,392
Northwest Territories..	1961	302	19,637
	1962	233	33,766
	1963	685	62,849
	1964	1,110	81,926
Canada.....	1961	562,720	59,707,964
	1962	703,601	87,427,726
	1963	754,163	96,252,159
	1964	733,489	106,497,974

(1) Includes dependents.
(2) Payment figures shown are for the months to which the claims made under the program relate and include amounts paid to the provinces by the federal government after the end of the fiscal year.
(3) Includes persons of a class formerly granted aid under a mothers' allowances program.

Subsection 6 - Fitness and Amateur Sport

The fitness and amateur sport program promotes active leisure pursuits for everyone in Canada. The program began in December 1961 when the Fitness and Amateur Sport Act, administered by the Minister of National Health and Welfare and providing up to five million dollars a year to be spent on encouragement, promotion, and development, came into effect. Although the federal, provincial, and municipal governments provide the funds and resources, the programs themselves are carried out almost entirely by non-governmental agencies. Under the Act, Canadian participation in active recreation and amateur sport can be promoted internationally, nationally, provincially, and locally through financial assistance, technical guidance, the provision of teaching materials, assistance to training, research, and the construction of facilities.

The National Advisory Council. The National Advisory Council of Fitness and Amateur Sport advises the Minister of National Health and Welfare under the Act. Its 30 members are chosen for their interest and experience and so that at least one member comes from each province. It studies and evaluates progress, recommends acceptance or rejection of applications for grants, and keeps in touch with national organizations concerned with fitness and amateur sport.

The Federal Program. The federal program has five elements: grants to national organizations; grants for athletic events of nationwide interest; grants for training and research; technical advice, training material, and promotional aids from the Department of National Health and Welfare; and grants to the provinces.

Grants to National Organizations. Federal grants totalling more than a million dollars a year go to some fifty national fitness and sporting organizations to help train coaches, to improve standards of instruction, to increase participation in sports, to aid the holding of national and regional competitions, and to assist Canadian athletic teams at international competitions, such as the Olympic Games and the Commonwealth Games.

Grants for Athletic Events. Other federal grants will assist the holding of the 1967 Pan-American Games in Winnipeg and the 1967 Canadian Winter Games in the Quebec area.

Grants for Training and Research. The program provides grants-in-aid for postgraduate study in fitness and amateur

sport and for research fellowships, and scholarships and bursaries for undergraduate study in Physical Education and Recreation. Grants are also made for research into matters related to fitness, and "Fitness Research" units have been established in some universities.

The Research Committee of the National Advisory Council, which is composed of leading scientists, reviews applications for aid and makes recommendations on general program policy to the Council.

The Canadian Documentation Centre on Fitness and Sport, located at the University of Ottawa, was established with the aid of funds from the program to provide a library and reference service.

Services of the Department of National Health and Welfare.

(a) Information. Visual aids for coaching, printed guides on particular sports and recreational activities, and technical information on the construction and use of facilities are being produced under the program. Typically-Canadian sporting and recreational activities have been fostered by "How To" kits that include an illustrated manual, a film to rouse interest in the subject, and films in which techniques are demonstrated. These kits and other films on sports and recreational activities are available on loan from the Department's Fitness Film Library.

(b) Advice and Co-ordination. Committees of the National Advisory Council meet frequently with the executives of sports organizations to discuss policy. A federal-provincial committee of government officials under the chairmanship of the Deputy Minister of Welfare advises on and co-ordinates governmental aspects of the program. The Department of National Health and Welfare is also responsible for co-ordinating any work done by other federal agencies in fitness and amateur sport. Consultants of the Department collaborate with sports agencies, and provide advice, on request, on the planning of activities and the use of funds.

Grants to the Provinces. Federal grants totalling $1 million each year are made to provinces that enter into three-year cost-sharing agreements for provincial programs of fitness and amateur sports. Under the agreements the federal government meets 60 per cent of the cost of projects and the full cost of the scholarships and bursaries. Applications for all grants at the provincial or local level are made in the first instance to the responsible provincial department.

The Municipal Role. The bulk of recreational activity occurs, after all, in the individual community. The municipal recreation departments co-ordinate community effort, provide continuity for voluntary organizations, and make long-range recreational plans. Ideas originate to a large extent in the municipal recreation departments, where the needs of the communities are best known.

Subsection 7 - National Welfare Grants

The National Welfare Grant program, established in November 1962, is designed to help develop and strengthen welfare services in Canada. In the year ended March 31, 1966, $1,500,000 was allocated to the program, which is scheduled to grow at the rate of $500,000 per annum until it reaches a yearly allocation of $2,500,000. The program consists of a General Welfare and Professional Training Grant and a Welfare Research Grant. Provincial governments, municipal welfare departments, nongovernmental welfare and correctional agencies, universities, and individuals may be the ultimate recipients of grants under one or more provisions of the program. Some are financed and administered entirely by the federal government; others require application through a provincial department of welfare that actually makes the award on a cost-sharing basis with the federal government.

General welfare, bursary, training, and staff development grants are shared provisions. General welfare grants provide funds for projects to improve welfare administration, to develop provincial consultative and coordinating services, and to strengthen and extend public and voluntary welfare services in child welfare, aging, general assistance, and other welfare fields. Bursaries are provided for full-time graduate training at Canadian schools of social work, and training grants are available for employees of government and voluntary welfare agencies who are granted educational leave for this purpose. Staff development grants provide support for a wide variety of staff training programs for personnel employed, or to be employed, in public and nongovernmental welfare agencies at the direct service, supervisory, and administrative levels, where such training can be justified as a means of achieving more effective and efficient administration.

The other provisions of the program are administered and entirely financed by the federal government. Welfare scholarships are awarded, on the basis of annual nation-wide competition, for graduate study in Canadian schools of social work, to a limited number of applicants who have completed

at least their undergraduate studies with high academic standing. Fellowships are awarded in the same way for advanced study at Canadian and foreign universities to applicants who have demonstrated leadership qualities and ability in the fields of administration, teaching, and research in Canadian welfare. Teaching and field instruction grants assist Canadian schools of social work with the salaries of additional staff required to implement the welfare grant program.

Under the Welfare Research Grant, funds are provided for a variety of surveys, studies, and research projects undertaken by public and voluntary welfare and correctional agencies, universities, and research institutions. Priority is given to those projects holding promise of significant progress in the organization, co-ordination, and staffing of existing welfare services and in the development of new services focused on the prevention of welfare problems and dependency.

Expenditures under the program for the year ended March 31, 1964, appear in Table 20.

Subsection 8 - Vocational Rehabilitation

The nation-wide vocational rehabilitation program, started in 1952, was consolidated and extended under the Vocational Rehabilitation of Disabled Persons Act, 1961. Under federal-provincial agreements to share equally the costs of co-ordination, assessment, and provision of services to disabled individuals, of training personnel, and of research, the provinces have developed comprehensive programs in co-operation with existing services. Approved services comprise medical, social, and vocational assessment, counselling, restorative services, vocational training, and employment placement. They are designed to assist individuals having a substantial physical or mental disability to become vocationally useful in gainful employment or in the home. A provincial co-ordinator of rehabilitation is responsible for the co-ordination and administration of vocational rehabilitation services to disabled individuals in each province. In 1965, the provincial rehabilitation staff employed in the vocational rehabilitation programs totalled 230.

The National Co-ordinator of Rehabilitation in the federal Department of Labour administers the federal aspects of this program. The National Advisory Council on the Rehabilitation of Disabled Persons advises the Minister of Labour and is composed of representatives of the provinces,

TABLE 20 - EXPENDITURES UNDER THE NATIONAL WELFARE GRANTS PROGRAM, BY PROVINCE, YEAR ENDED MARCH 31, 1964

Province	Research	Bursaries	Fellowships and scholarships	Training grants	Teaching and field instruction	Staff development	Welfare services	Total
	$	$	$	$	$	$	$	$
Newfoundland	-	600	-	3,579	-	5,173	-	9,352
Nova Scotia	1,667	-	-	8,109	5,522	4,961	-	20,259
New Brunswick	560	2,474	-	2,087	-	4,798	-	9,919
Quebec	-	-	5,858	-	-	-	-	5,858
Ontario	32,174 1/	13,889	32,189	1,514	37,545	15,545	21,005	153,861
Manitoba	-	2,325	1,328	12,865	16,817	-	-	33,335
Saskatchewan	6,876	5,389	-	9,622	-	-	-	21,887
Alberta	-	-	2,009	5,585	-	3,779	9,379	20,752
British Columbia	16,675 1/	500	16,281	1,460	13,476	3,383	14,402	66,177
Yukon Territory	-	-	-	1,370	-	-	-	1,370
CANADA	57,952	25,177	57,665	46,191	73,360	37,639	44,786	342,770

1/ Includes payments made to schools of social work and to voluntary agencies located in the province.

employers, labour, the medical profession, national voluntary agencies, and the universities. In the year ended March 31, 1965, federal-provincial expenditures under the program (exclusive of vocational training) totalled $1,284,424. Full reports were received on 2,179 disabled persons rehabilitated during the year; before rehabilitation the majority of these persons and their dependents relied on private or public assistance for support at an estimated annual cost of $1,500,000, but following rehabilitation the estimated annual earnings by those gainfully employed was $4,600,000.

In 1958, with the establishment of the Division on Older Workers, the Department of Labour's educational efforts designed to encourage a more favourable employment climate for older workers became centred in the National Co-ordinator's office. The Division's functions include the development of a long-range educational program; the encouragement of research; the maintenance of liaison with employer and labour organizations and voluntary agencies in Canada and other countries; and the assembly and dissemination of information. The Division is gradually becoming widely known as a central source of information on the employment problems of older persons.

Medical rehabilitation, vocational training, and special employment services for the handicapped are available as integral parts of the federal-provincial rehabilitation program. The Technical and Vocational Training Assistance Act, administered by the Department of Labour, provides for equal sharing by Canada and the provinces of the cost of approved programs for the training of disabled persons for gainful employment. During 1964-65 there were 3,981 disabled persons enrolled in various courses; federal payments amounted to $646,000. Referrals for job placement are made to some 380 special services officers in 144 local offices. Special placements of handicapped persons who required assistance in finding work in 1964-65 (including those referred from provincial rehabilitation authorities) numbered 22,198.

Federal government programs also providing direct services for particular groups are administered by the Department of Veterans Affairs for disabled, chronically ill, and aged veterans, by the Department of Citizenship and Immigration for disabled and handicapped Indians, and by the Department of Northern Affairs and National Resources for the training and resettlement of disabled Eskimos and Indians within its jurisdiction.

Section 3 - Provincial Welfare Programs

Major welfare programs governed by provincial legislation include general assistance and social allowances, mothers' allowances, services for the aged, and child care and protection. In most provinces responsibility for a number of the programs is shared by the provinces and their municipalities. Provincial administration of welfare services is carried out through the department of public welfare in each province; several departments have established regional offices to facilitate administration and to provide consultative services to the municipalities.

Provincial departments of public welfare are placing increasing emphasis on standards of administration and on rehabilitative services for social assistance recipients. All provinces continue to extend and improve services on behalf of older citizens and efforts are being made to assess their particular needs. In Ontario, for example, the Legislative Assembly established on May 8, 1964 a Select Committee on Aging to enquire into problems of major concern to older citizens, and to make appropriate recommendations to the Legislature.

The main efforts in child welfare have been directed toward improvement of standards and greater flexibility of services, with particular emphasis on preventive casework services for children in their own homes, the development of specialized children's institutions, "group living homes" for teenaged children, and the finding of adoption homes for all children in need of them.

The public services are supplemented by an impressive number of voluntary agencies that also contribute to community welfare by assisting the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups, and released prisoners. Welfare councils and social planning councils contribute to the planning and co-ordinating of local welfare services. Local voluntary agencies and institutions may receive public grants, depending on the nature and standard of the services they render, although, with the exception of the semi-public children's aid societies, their main support may be from united funds or community chests, or from sponsoring organizations.

Subsection 1 - Mothers' Allowances

All provinces make provision for allowances to needy mothers. A number of provinces combine such allowances into a broadened program of provincial allowances to persons in several categories of long-term need or have incorporated this legislation with general assistance within a single act, while continuing separate administration. In British Columbia, on the other hand, aid is provided to needy mothers under the general assistance program on the same basis as to other needy persons.

Subject to conditions of eligibility which vary from province to province, mothers' allowances or their equivalents are payable from provincial funds to applicants who are widowed, or whose husbands are mentally incapacitated or are physically disabled and unable to support their families. They are also payable to deserted wives who meet specified conditions; in several provinces to mothers whose husbands are in penal institutions, or who are divorced or legally separated; in some, to unmarried mothers; and in Ontario, Quebec, and Nova Scotia, to Indian mothers. Foster mothers may be eligible under particular circumstances in most provinces.

The age limit for children is 16 years in most provinces, with provision made to extend payment for a specified period if the child is attending school or if he is physically or mentally handicapped. In all provinces applicants must satisfy conditions of need and residence but the amount of outside income and resources allowed and the length of residence required prior to application vary, the most common period being one year. One province has a citizenship requirement.

The number of families and children assisted in each province as at March 31, 1964, together with the amounts of benefits paid during the year are given in Table 21 and rates of benefits as at March 1965 in Table 22.

TABLE 21 - MOTHERS' ALLOWANCE STATISTICS, BY PROVINCE, AS AT MARCH 31, 1961 TO 1964

Province and year		Families assisted	Children assisted	Payments during the year ended March 31
		No.	No.	$
Newfoundland.....	1961	4,211	11,924	4,061,239(a)
	1962	4,498	12,315	4,308,762
	1963	4,836	13,216	4,687,760
	1964	5,172	14,418	5,100,590
Prince Edward Island...	1961	256	635	124,099
	1962	269	649	131,300
	1963	293	747	140,885
	1964	314	778	212,265
Nova Scotia.....	1961	2,658	6,575	2,166,163
	1962	2,754	7,452	2,258,875
	1963	2,760	7,477	2,311,725
	1964	3,331	8,100	2,533,311
New Brunswick.....	1961	2,212	6,501	1,398,808
	1962	2,119	6,178	1,356,078
	1963	2,165	6,287	1,347,479
	1964	2,254	6,364	2,030,948
Quebec.....	1961	20,309	52,803	19,314,014
	1962	19,842	52,462	19,479,716
	1963	19,531	54,638	20,743,405
	1964	19,222	54,366	22,538,118
Ontario.....	1961	10,149	26,143	12,877,821
	1962	10,359	25,537	13,650,401
	1963	10,175	25,522	13,913,657
	1964(b)	10,700	27,600	15,553,856

TABLE 21 - MOTHERS' ALLOWANCE STATISTICS, BY PROVINCE, AS AT MARCH 31, 1961 TO 1964 (Concluded)

Province and year		Families assisted	Children assisted	Payments during the year ended March 31
		No.	No.	$
Manitoba.....	1961(a)	1,350	3,582	2,072,594
	1962(a)	1,638	3,635	2,360,594
	1963	1,811	3,823	2,576,796
	1964	1,845	4,150	2,776,762
Saskatchewan.....	1961	2,316	5,695	1,957,403
	1962	2,382	5,837	2,679,587
	1963	2,459	6,158	3,512,769
	1964	2,466	6,255	3,669,427
Alberta.....	1961	2,457	5,565	2,273,162
	1962	1,611	3,319	1,879,195
	1963(c)	1,210	2,361	1,407,020
	1964(c)	931	1,760	1,009,867
British Columbia(d)....		..	..	..
		..	..	..
		..	..	..
Canada(e).....	1961	45,918	118,423	46,245,303
	1962	45,477	117,384	48,104,508
	1963	45,240	120,229	50,641,496
	1964	46,235	123,791	55,425,144

(a) Approximate.
(b) Includes dependent fathers assisted under the General Welfare Assistance Act.
(c) In 1963 an additional 2,563 families with 7,542 children were assisted under Part III of the Public Welfare Act, and in 1964, an additional 3,275 families with 9,774 children were so assisted; cost of allowances for this group is included in total payments for all groups receiving aid under Part III.
(d) Caseload social assistance; no separate figures are available.
(e) Exclusive of British Columbia.

TABLE 22 - MAXIMUM MONTHLY RATES UNDER PROVINCIAL MOTHERS' ALLOWANCES PROGRAMS, MARCH 1965

Province	Mother and one child	Each additional child	Disabled father at home	Family maximum	Supplementary
Nfld.....	Food: $35 or $37 depending on age of child. Clothing: $10 for mother; $5 for child. Rent: up to $25 monthly in rural and to $50 monthly in urban areas. Fuel: up to $15.	Food: $10 for each child under age 16; $12 for each child age 16 or over. Clothing: $5	$20	None set	In special circumstances up to $30 a month additional if necessary for proper support of family.
P.E.I....	$70	$5	No additional allowance granted.	$125	None granted.
N.S.....	No set maximum; rates are based on average family income for community in which family lives.		Included in budget on which allowance is based.	$90	None granted.
N.B.....	$60	$10	No additional allowance granted.	$115	Director may grant an additional $10 for rent if circumstances require if, but only if allowance paid is below maximum.
Que.....	$85	$10	$10	None set (minimum granted $5)	A supplementary allowance may be granted according to need.

TABLE 22 - MAXIMUM MONTHLY RATES UNDER PROVINCIAL MOTHERS' ALLOWANCES PROGRAMS, MARCH 1965

(Continued)

Province	Mother and one child	Each additional child	Disabled father at home	Family maximum	Supplementary
Ont.....	Food, clothing, and household sundries: $63.45-$69.45 depending on age of child. Shelter: rent to $76.50 for unheated premises, $85 for heated premises, or payments on mortgage and taxes up to $76.50. Utilities: up to $8.50 $40 for one child living with foster mother.	Food and clothing according to age of child: $17.70-$23.70 for 2nd child, $19-$25 for 3rd child, $18-$24 for 4th child, $17-$23 for each child in excess of 6. Additional amounts of $3 for girl 13-19 years, $5 for boy 13-15 years, $8 for boy 16-19 years. $75 for two foster children, $25 for each additional foster child.	Dependent fathers and their families are aided under the General Welfare Assistance Act.	$300	An increase in food allowance may be granted on medical recommendation. A fuel allowance of up to $29 a month may be granted from September 1 to March 31. An increase of 20% in fuel allowance may be granted under special circumstances.
Man.....	Food, clothing, household, and personal needs: $52-$64 depending on age of child. Shelter: rent to $55, or current taxes and insurance at actual cost, minor repairs to $125 a year, principal and interest on mortgage or agreement for sale up to $55 less taxes and insurance. Utilities: up to $7.	$14 for child up to 3 years; $16 for child 4-6 years; $21 for child 7-11 years; $26 for child 12-18 years (Subject to deductions for 4th and each additional child).	$25	None set.	$10 for rent if necessary. Housekeeper service as required. Fuel allowance for eight months. For special needs not covered by basic schedule items, up to $150 a year.

TABLE 22 - MAXIMUM MONTHLY RATES UNDER PROVINCIAL MOTHERS' ALLOWANCES PROGRAMS, MARCH 1965

(Concluded)

Province	Mother and one child	Each additional child	Disabled father at home	Family maximum	Supplementary
Sask.....	Food, clothing, household and personal needs: $51.80-$67.00 depending on age of child. Rent: $40 Fuel: up to $15.15 Utilities: up to $11.	$17.40 for preschool child; $24.35 for child 6-11 years; $29.30 for child 12-15 years; $32.60 for child 16-18 years. (Subject to reductions for fourth and each additional person).	$31.50	None set.	Special food allowance may be granted on medical recommendation. An allowance for a housekeeper may be granted if necessary.
Alta.....	Food and clothing: $53.87-$27.27 depending on age and sex of child. Rent, fuel, utilities: according to community standards.	$16.00 for food and clothing for infant under 1 year. $12.10-$28.30 for food for child 1-18 years depending on age and sex. $5.30-$10.00 for clothing for child 1-19 years depending on age and sex, subject to 10% increase in food allowance for a family of two and a deduction of 5% in the allowance for food and clothing for a family of seven or more.	$31.60	None set.	An increase in food allowance may be granted on medical recommendation.
B.C.....	Allowances to needy mothers provided under the Social Assistance Act, and not separable.		...	...	...

Subsection 2 - General Assistance

All provinces make legislative provision for general assistance on a means or needs test basis to needy persons and their dependents who cannot qualify for other forms of aid, and some provinces include those whose benefits under other programs are not adequate. Where necessary the aid may be for maintenance in homes for special care. Besides financial aid for the basic needs of food, clothing, shelter, and utilities, a number of provinces also provide incapacitation or rehabilitation allowances, counselling and homemaking services, and post-sanatorium care. This assistance is administered by the province or by the municipalities with substantial financial support from the province, which, in turn, is reimbursed by the federal government under the Unemployment Assistance Act for 50 per cent of the provincial and municipal assistance given (see p.80).

The provincial departments of public welfare have regulatory and supervisory powers over municipal administration of general assistance and may require certain standards as a condition of provincial aid. Length of residence is not a condition of aid in any province, but the residence of the applicant as defined by statute determines which municipality may be financially responsible for his aid. This rule does not apply in three provinces: British Columbia and Saskatchewan have equalized municipal payments and Quebec does not require its municipalities to contribute to general assistance costs. Provinces with unorganized areas take responsibility for aid in these districts. Under the federal Unemployment Assistance Act, all provinces have agreed that residence shall not be a condition of assistance for applicants who move from one province to another. For persons without provincial residence (usually a period of one year), aid may be given by the province or the municipality and a charge-back may or may not be made to the province or municipality of residence.

The formula for provincial-municipal sharing of costs is determined by the province. In Newfoundland, general assistance is the responsibility of the province and is administered by the Department of Public Welfare. In Prince Edward Island, the Department of Welfare and Labour provides direct social assistance in rural areas and assumes 75 per cent of the cost of assistance granted by the City of Charlottetown and the incorporated towns and villages; aid to needy families where the breadwinner is suffering from tuberculosis is borne entirely by the province. In Nova Scotia, assistance is administered by the municipality, which receives reimbursement from the Department of Public Welfare for two-thirds of the cost of the aid provided and one-half of the cost of administration;

allowances for certain disabled persons are administered by the province. In New Brunswick, the province reimburses each municipality to the extent of one dollar per capita of the population plus 70 per cent of expenditures on general assistance in excess of that amount, and also pays 50 per cent of the cost of administration.

In Quebec, the Department of Family and Social Welfare reimburses authorized agencies and municipal departments for the full cost of aid to persons in their own homes. It takes full responsibility for aid to persons who are unfit for work for at least 12 months, for supplementary allowances and allowances to needy widows and spinsters 60-65 years of age. The cost of aid to unemployable persons in homes for special care, including nursing homes, is borne two thirds by the province and one third by the institution. In Ontario, the Department of Public Welfare reimburses municipalities up to a prescribed maximum for 80 per cent of their expenditures for general welfare assistance, and for 90 per cent of expenditures for aid to persons in excess of a given proportion of the population in the municipality. Aid for rehabilitation services and aid on behalf of foster children, for which the municipalities are reimbursed 50 per cent, are excluded in these calculations. The province administers allowances to needy widows and unmarried women 60 years of age or over.

In Manitoba, the province administers aid to mentally or physically incapacitated persons whose disability is likely to last more than 90 days, and to persons unable to work because of their age. Aid to other needy persons, termed indigent relief, is the responsibility of the municipalities, which are reimbursed through the provincial Department of Welfare to the extent of 40 per cent of the costs, or at a higher rate if costs exceed a specified amount. In Saskatchewan, through the Department of Social Welfare and Rehabilitation, the province reimburses the municipalities for approximately 93 per cent of the cost of assistance granted to needy persons. In Alberta, the province reimburses the municipalities for 80 per cent of the value of the assistance given. The provincial Department of Public Welfare has full responsibility for allowances payable to persons who are mentally or physically handicapped for a period likely to last for more than 90 days, and to persons who because of their age are not able to be self-supporting. The Department maintains two hostels and one welfare centre to care for unemployable single homeless men without municipal domicile.

British Columbia, through its Department of Social Welfare, reimburses the municipalities on a pooled basis for 90 per cent of the total cost of social assistance to needy persons. Also, the province shares equally with the municipalities

expenditures on salaries of social workers; a municipality with fewer than 15,000 persons may arrange to have the Department undertake social work within the municipality and reimburse it at the rate of 60 cents per capita per year.

Subsection 3 - Living Accommodation for Elderly Persons

In all provinces, homes for the aged and infirm are provided under provincial, municipal, or voluntary auspices. Voluntary homes generally are provincially inspected in accordance with prescribed standards and in some provinces must be licensed. Most provinces contribute to the maintenance of needy persons in homes for the aged, either through general assistance or through statutes that relate particularly to these homes. Also, 50 per cent of the payments on behalf of assistance cases in homes for the aged and infirm (homes for special care) are met by the federal government (see p.77).

Several provinces make capital grants toward the construction of homes, and in five provinces capital grants are also available to municipalities, voluntary organizations, or limited-dividend companies for the construction of low-rental housing.

Newfoundland maintains a home for the aged and infirm at St. John's and pays part or all of the cost of maintaining needy old people in homes for the aged and boarding homes. Provision is made for grants to organizations constructing homes for the aged. The province is authorized by the Senior Citizens (Housing) Act, 1960 to guarantee the repayment of loans made under the National Housing Act to limited-dividend companies constructing hostels or housing for the elderly and to guarantee the cost of operating such projects. The aged and infirm in Prince Edward Island are cared for in two institutions operated by the Department of Welfare and Labour. In Nova Scotia, the aged are cared for in municipal or county homes, in homes operated by religious or private organizations, and in private boarding homes. The province reimburses the municipalities for two-thirds of their expenditures for the maintenance of needy persons in municipal homes, subject to compliance with specified standards of care and accommodation. Homes for the aged receiving aid from the provincial government are subject to provincial inspection. Homes for the aged in New Brunswick are operated under municipal, religious, fraternal, and private auspices and receive no direct financial support from the province. Voluntary and proprietary homes are subject to provincial licensing and inspection and must meet standards contained in regulations under the Health Act. Under the Social Assistance Act, 1960, the province contributes to the maintenance of needy persons in municipal homes.

Institutional care for indigent old people in Quebec is provided through charitable institutions under the Public Charities Act. The Homes for the Aged Act authorizes the province to erect and maintain homes for the aged and housing projects, or to make grants to voluntary organizations for this purpose. Standards in homes are governed by regulations under the Public Health Act.

Under the Ontario Homes for the Aged Act, municipalities must provide institutional or boarding-home care for the aged. The province contributes 50 per cent of the costs of construction of approved homes and 70 per cent of their net operating and maintenance costs. It also pays up to 70 per cent of the costs of maintenance in approved boarding homes. Homes for the aged under voluntary auspices are approved, inspected, and assisted under the Charitable Institutions Act, which provides for grants in aid of construction equalling 50 per cent of costs up to $2,500 per bed and maintenance grants of 75 per cent of the amount spent by the organization up to $6.00 per day for each resident where the institution maintains a bed-care unit of 20 beds and $4.00 where it does not. The Elderly Persons Housing Aid Act provides for grants to limited-dividend housing corporations building low-rental housing for elderly persons.

Institutions and boarding homes for the aged and infirm in Manitoba are supervised and licensed by the Department of Health under public health legislation. Under the Elderly and Infirm Persons Housing Act, the province makes construction grants to municipalities and charitable organizations equalling one-third of the costs of constructing or of acquiring and renovating housing accommodation and homes for the aged. Grants may not exceed $1,700 for one-person housing units, $2,150 for two-person housing units, $2,000 per bed for new homes for the aged, and $1,000 per bed for homes that have been renovated. Under the Social Allowances Act, 1959, the province bears the entire cost of assistance to those who, because of age or incapacity, require care for more than 90 days by another or in a home for the aged.

Aged and infirm persons in Saskatchewan are cared for in four provincial nursing homes and in voluntary homes for the aged. The latter are inspected and licensed under the Housing Act. This Act also empowers the province and municipalities to subscribe to the stock of limited-dividend housing companies building low-rental accommodation for older persons; the province may also make loans to municipalities to assist them in subscribing. Capital grants amounting to 20 per cent of construction costs and annual maintenance grants of $40 for each self-contained housing unit and $60 for each hostel or nursing-home bed may be made to municipalities, churches, or

charitable organizations sponsoring approved homes or housing projects. Costs of maintaining needy persons in homes for the aged are shared by the province and the municipalities under the Social Assistance Act.

Under what are termed 'master agreements', Alberta bears the cost of constructing and equipping homes for the aged and housing units on municipal land. Projects are operated by provincially incorporated foundations which include municipal councilmen in their membership; net costs of operation are borne by the municipalities. The province also meets up to 80 per cent of the cost incurred by municipalities for the maintenance of elderly persons in housing projects and municipal or private homes. Private homes are municipally licensed.

British Columbia operates a home for elderly homeless men, a provincial infirmary for the chronically ill, and, for senile and psychotic patients, three provincial homes for the aged. It also licenses and supervises homes for the aged and boarding homes and, where necessary, shares with the municipalities on a 90-10 basis the cost of maintaining needy residents. Under the Elderly Persons Housing Aid Act, the province makes grants amounting to one-third of construction costs to municipalities and nonprofit corporations, including religious and service organizations, engaged in building homes or low-rental housing units for elderly citizens.

Subsection 4 - Recreational Centres for Elderly Persons

Ontario has given an impetus to the provision of recreation centres for the elderly through the passing in 1962 of the Elderly Persons Social and Recreational Centres Act. This Act provides for a provincial grant of up to 30 per cent of the cost of constructing or buying a building for use as a centre if the municipality contributes 20 per cent.

Subsection 5 - Child Welfare Services

Child welfare services, which include child protection and care, services for unmarried parents, and adoption services, are provided in all provinces under provincial legislation and are administered by a division of child welfare within the provincial department of welfare. The program may be administered by the provincial authority or the responsibility may be delegated to local children's aid societies, that is, to voluntary agencies with boards of directors, operating under charter and under the general supervision of provincial

departments; in Quebec, child welfare services are administered by recognized voluntary agencies and institutions, religious and secular. In Newfoundland, Prince Edward Island, Saskatchewan, and, to a large extent, in Alberta, they are administered by the province; in the larger urban centres of Alberta there is some delegation of authority to the municipality. In Ontario and New Brunswick, a network of local children's aid societies, operating under statutory authority, is responsible for the services. In Nova Scotia, Manitoba, and British Columbia, services are administered by local children's aid societies in the heavily populated areas and by the province in other areas.

Children's aid societies and the recognized agencies in Quebec receive substantial provincial grants and sometimes municipal grants and in many areas they also receive support from private subscriptions or from community chests or united funds. Maintenance costs for children in care of a voluntary or public agency may be borne entirely by the province -- as in Alberta, Saskatchewan, Manitoba, Prince Edward Island, and Newfoundland--or partly by the municipality of residence and partly by the province.

The child welfare agencies, provincial or private, have the authority to investigate cases of alleged neglect and, if necessary, to apprehend a child and to bring the case before a judge upon whom rests the responsibility of deciding whether in fact the child is neglected. When neglect is proven, the court may direct that the child be returned to his parent or parents, under supervision, or be made a ward of the province or a children's aid society or, in Quebec, be placed under the authority of a suitable person or agency. The appropriate agency is then responsible for making arrangements to meet the needs of the child in so far as community resources permit. The services may involve casework with families in their own homes, or care may be provided in foster boarding homes, in adoption homes or, for children who need this form of care, in selected institutions. Children placed for adoption may be wards or they may be placed on the written consent of the parent. Adoptions, including those arranged privately, number about 13,000 annually.

Child welfare agencies make use of the small selective institution for placement of children who are forced to be away from their own homes for a short period or who may need preparation for placement in foster homes, and emphasis is increasingly being placed on group-living homes for teen-age children. The development of small, highly specialized institutions, which function as treatment centres for emotionally disturbed children, is of particular significance. Institutions for children are governed by provincial child

welfare legislation or by special statutes dealing with welfare institutions, and by provincial or municipal public health regulations. The institutions are generally subject to inspection and in some provinces to licensing, and are usually required to make reports to the province on the movement of children under their care. Sources of income may include private subscriptions, provincial grants, and maintenance payments on behalf of children in care, payable by the parents, the placing agency, or the responsible municipal or provincial department.

Services to unmarried parents include casework services to the mother and possibly to the father, legal assistance in obtaining support for the child from the father, and foster-home care or adoption services for the child. Support for unmarried mothers may be obtained under general assistance programs. In many centres, homes for unmarried mothers are operated under private or religious auspices.

Day nurseries for the children of working mothers are established only in the larger centres and chiefly under voluntary auspices. Licensing is required in five provinces but Ontario is the only province with a Day Nurseries Act. This sets out standards for operation and licensing and provides for provincial reimbursement of one-half of the operating and maintenance costs of municipally sponsored day nurseries, which are established in most of the industrial centres in that province.

Section 4 - International Welfare

Canada plays an active role in a number of international agencies concerned with social welfare development. These include the United Nations Social Commission, which studies and reports on world social conditions, including such special aspects as levels of living, community development, social services, and social defence. Canada is a member of the Executive Board of the United Nations Children's Fund(UNICEF) which provides assistance to mothers and children in less-developed countries. Other international agencies with welfare interests, in whose work Canada participates, include the International Labour Organization and the International Social Security Association. Through the Colombo Plan and other bilateral aid programs, Canada provides social welfare assistance as well as other kinds of help to developing countries.

In addition to these activities and contributions by the Canadian government, Canadian voluntary agencies are also

active internationally, in providing aid to developing countries and participating in international discussion of welfare matters.

This work, whether governmental or voluntary, has taken on new significance in the United Nations Development Decade, with the growing realization throughout the world that progress depends upon people as much as upon machines and materials. With her pioneering experience at many levels of social development, Canada is equipped to give special assistance in the promotion of human welfare abroad.

PART III - HEALTH AND SOCIAL WELFARE EXPENDITURES

Section 1 - Government Expenditures on Health and Social Welfare

In the six years from 1958-59 to 1963-64, expenditures of all levels of government on health and social welfare grew from $2,821 million to $4,087 million, an increase of 44.9 per cent. If these figures are adjusted in order to take account of the growth in population, the increase in per capita expenditures, from $164 to $215, is about 31 per cent. Government expenditures may also be measured in relation to major economic indicators; on this basis government expenditures on health and social welfare rose over the period under review from 11.1 to 12.3 per cent of net national income and from 8.4 to 9.3 per cent of gross national product.

The federal share of health and social welfare expenditures fell from 73.9 per cent in 1958-59 to 68.5 per cent in 1963-64. Over the same period the provincial share rose from 22.2 to 28.5 per cent and the municipal percentage declined from 3.9 to 3.0.

Of considerable interest has been the growing proportion of government expenditures on health and social welfare taken up by health programs; in 1958-59, such programs accounted for $624 million or 22 per cent; by 1963-64, the outlays amounted to $1,365 million or almost 34 per cent.

An outline of the principal components for the fiscal year 1963-64 indicates the magnitude of the major programs and services. Family allowances payments amounted to $538 million, old age security payments to $808 million, and unemployment insurance benefits to $366 million. Veterans' pensions and allowances accounted for $173 million and $83 million respectively, and payments from the Prairie Farm Emergency Fund totalled $10 million. These income maintenance programs were entirely the responsibility of the federal government. Federal-provincial income maintenance programs required expenditures of $78 million on old age assistance, $7 million for blindness allowances, $40 million for disabled persons' allowances, and over $214 million for unemployment assistance, the latter figure including some municipal expenditure. Workmen's Compensation Boards spent $112 million on cash benefits for pensions and compensation and the provincial governments about $43 million on mothers' allowances.

TABLE 23 - GOVERNMENT EXPENDITURES ON HEALTH AND SOCIAL WELFARE: TOTAL AMOUNT, PER CAPITA AMOUNT, AND PERCENTAGE DISTRIBUTION, BY LEVEL OF GOVERNMENT, FISCAL YEARS 1958-59 TO 1963-64

Fiscal year	Federal	Provincial	Municipal	Total
	Expenditures (millions of dollars)			
1958-59	2,084.7	627.4	109.3	2,821.3
1959-60	2,162.2	754.7	106.4	3,023.3
1960-61	2,359.9	885.7	109.0	3,354.6
1961-62	2,575.8	998.1	107.8	3,681.8
1962-63	2,682.3	1,082.7(a)	117.3	3,882.2
1963-64	2,799.7	1,164.4(b)	123.0(b)	4,087.1
	Per capita expenditures (dollars)			
1958-59	121.53	36.57	6.37	164.47
1959-60	123.20	43.00	6.06	172.27
1960-61	131.28	49.27	6.06	186.62
1961-62	140.32	54.37	5.87	200.57
1962-63	143.57	57.95	6.28	207.79
1963-64	147.26	61.25	6.47	214.98
	Percentage distribution			
1958-59	73.9	22.2	3.9	100.0
1959-60	71.5	25.0	3.5	100.0
1960-61	70.4	26.4	3.2	100.0
1961-62	70.0	27.1	2.9	100.0
1962-63	69.1	27.9	3.0	100.0
1963-64	68.5	28.5	3.0	100.0

(a) Preliminary.

(b) Estimated.

TABLE 24 - EXPENDITURES OF ALL LEVELS OF GOVERNMENT ON HEALTH AND SOCIAL WELFARE IN RELATION TO NET NATIONAL INCOME AND GROSS NATIONAL PRODUCT, FISCAL YEARS 1958-59 TO 1963-64

Fiscal year	Government expenditures on health and social welfare		
	Amount	Per cent of net national income	Per cent of gross national product
	(millions of dollars)		
1958-59	2,821.3	11.1	8.4
1959-60	3,023.3	11.3	8.5
1960-61	3,354.6	12.2	9.2
1961-62	3,681.8	12.8	9.7
1962-63	3,882.2(a)	12.6	9.5
1963-64	4,087.1(b)	12.3	9.3

(a) Preliminary figures for provincial component.

(b) Estimated figures for provincial and municipal components.

Welfare services for Indians and for veterans and the national employment service accounted for $38 million at the federal level while child welfare services required an expenditure of almost $51 million by provincial governments.

In the field of health, federal grants to the provinces under the Hospital Insurance and Diagnostic Services Act totalled $392 million and grants for hospital construction and general health grants to the provinces and municipalities amounted to $53 million. The Federal Government spent $29 million on its Indian and Northern Health Services and $46 million on hospital and treatment services for veterans. Provincial expenditures on hospital care are estimated to have totalled $620 million; in addition, $80 million was spent on other health services. Workmen's Compensation Boards paid $48 million for medical aid and hospitalization. Municipal governments spent $79 million on health.

Altogether, the components listed above accounted for expenditures of $3.9 billion in 1963-64.

Section 2 - Expenditures on Personal Health Care

Expenditures made in Canada on personal health care services, shown in Table 25, include for the purposes of this section the amounts spent by hospitals and the amounts received by physicians, dentists, pharmacists for prescription services, and other paramedical professionals, in the provision of health care and treatment directly to individuals.

No attempt is made to include expenditures on public health, or public or private capital expenditures such as the building or extension of hospitals or other health facilities. Also excluded are the cost of administration of public health programs and other technical services as well as the cost of administering voluntary profit or nonprofit health insurance plans. On the other hand, expenditures by the three levels of government on behalf of individuals are included.

Canadians spent an estimated $2,012 million in 1963 on personal health care, which is almost two and three-quarters times the $735 million they spent in 1953. The year-to-year rates of increase during that period varied from a minimum of 8.2 per cent, between 1954 and 1955, to a maximum of 13.6 per cent, between 1955 and 1956, and averaged 10.5 per cent.

Expenditures rose during the period 1953 to 1963 more

TABLE 25 - EXPENDITURES ON PERSONAL HEALTH CARE(a), CANADA, 1953-1963

Year	Hospital services					Physicians' services	Prescribed drugs(f,g)	Dentists' services	Other(g,h)	Total(e)
	Active treatment(b)	Mental(c)	Tuber-culosis(c)	Federal(d)	All hospitals(e)					
	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000
1953	280.4	57.8	29.4	36.4	404.0	176.6	48.8	60.5	45.0	734.9
1954	314.0	64.5	30.4	37.9	446.8	188.6	52.1	66.4	50.0	803.9
1955	342.4	68.9	29.9	38.8	480.1	206.5	59.5	68.6	55.0	869.7
1956	380.8	77.6	30.6	40.8	529.9	240.1	71.8	81.5	65.0	988.3
1957	422.9	87.5	31.0	45.3	586.8	269.2	84.5	87.3	70.0	1,097.8
1958	462.3	99.0	30.4	48.4	640.1	295.5	90.3	98.1	85.0	1,209.0
1959	542.6	111.6	29.6	50.3	734.1	326.8	106.5	100.1	95.0	1,362.5
1960	625.2	120.2	30.1	53.9	829.4	346.5	114.4	112.4	105.0	1,507.7
1961	714.8	132.8	29.9	56.8	934.3	374.0	121.3	118.8	115.0	1,663.4
1962	802.4	141.7	29.5	60.1	1,033.7	419.3	127.0	123.8	125.0	1,828.8
1963(g)	899.7	158.9	28.4	62.9	1,149.9	456.4	136.2	134.8	135.0	2,012.3

(a) Excluding expenditures on public health and for capital purposes.
(b) Including gross expenditures of public and private acute, chronic, and convalescent hospitals in 1953-1957 and, in non-participating provinces, in 1958-1960; including gross expenditures of budget review and contract hospitals in 1961-1963 and, in participating provinces, in 1958-1960; excluding expenditures of mental, tuberculosis, and federal hospitals.
(c) Including gross expenditures of public and private hospitals; excluding expenditures of federal hospitals.
(d) Including acute, chronic, convalescent, mental, and tuberculosis hospitals of the Department of National Health and Welfare and the Department of Veterans Affairs; excluding hospitals of the Department of National Defence.
(e) Items may not add to totals because of rounding.
(f) Sold by retail drugstores only.
(g) Estimated.
(h) Including expenditures for services of private duty nurses, and chiropractors, osteopaths, and optometrists; excluding all employees of hospitals.

rapidly than the population, which increased by 27.3 per cent. The per capita amount, which had been $49.51 in 1953, reached $98.48 in 1962 and went to an estimated $106.49 in 1963.

The proportion of the gross national product represented by expenditures on personal health care increased from 2.94 per cent in 1953 to 4.68 per cent in 1963, with a slight reduction between 1954 and 1955. In other words, one dollar in every 21 dollars of production in Canada in 1963 was for personal health care goods and services as compared with one dollar in 34 in the year 1953.

Payments received by physicians and surgeons for providing personal medical care services comprise about 23 per cent of total expenditures on personal health care, and were $456 million in 1963. See Section 3 and 4, below.

Section 3 - Earnings of Privately Practising Physicians in Canada

More than 95 per cent of the earnings of privately practising physicians and surgeons in Canada were obtained from fees charged for individual items of professional service. As Table 26 shows, average gross earnings in 1963 from fees plus wages and salaries earned incidental to fee practice were $28,367.

This figure was 9 per cent higher than in 1960 and 39 per cent above the 1957 figure. The highest gross earnings in 1963 were reported in Saskatchewan, at $34,031, and in Alberta and Ontario they were substantially above the national average. Average gross incomes in the remaining provinces were below the national average and ranged downward from $27,500 in British Columbia to $21,034 in Newfoundland.

Generally, throughout the seven-year period 1957-1963, highest average gross earnings have been most consistently reported in Ontario and the western-most provinces, with Alberta usually having the highest average of all.

The net returns to doctors, after deduction of the expenses of professional fee practice, reveal similar geographic patterns, as seen in Table 27. Net earnings for Canada as a whole averaged $18,799 in 1963. This figure was 8.8 per cent higher than in 1962 and about 49 per cent above the 1957 figure.

In 1963 the highest provincial average net income from professional fee practice was reported by Saskatchewan doctors.

TABLE 26 - AVERAGE GROSS PROFESSIONAL INCOMES [a] OF PHYSICIANS AND SURGEONS [b] CANADA BY PROVINCE, 1957 TO 1963

	1957	1958	1959	1960	1961	1962	1963
Newfoundland	17,893	19,003	18,988	21,483	21,072	19,235	21,034
Prince Edward Island	15,855	18,322	19,653	20,790	20,553	20,147	24,562
Nova Scotia	19,776	19,741	21,386	22,850	23,274	23,284	23,352
New Brunswick	17,559	19,787	19,161	22,908	24,728	24,548	27,017
Quebec	16,701	18,039	18,435	19,412	21,925	23,208	25,543
Ontario	21,707	23,100	23,780	25,217	26,972	27,558	30,442
Manitoba	22,757	23,968	26,172	24,537	27,648	27,508	27,260
Saskatchewan	22,669	23,426	23,510	26,853	26,884	23,016	34,031
Alberta	23,349	24,735	25,078	27,872	29,074	31,052	30,902
British Columbia	22,968	24,171	25,999	27,483	28,536	27,350	27,500
Canada	20,472	21,760	22,514	23,917	25,471	26,002	28,367

(a) Professional gross income, including incidental wages and salaries; these data are completely revised and supersede material published in earlier editions.

(b) Taxable physicians and surgeons only.

TABLE 27 - AVERAGE NET PROFESSIONAL INCOMES[a] OF PHYSICIANS AND SURGEONS[b] CANADA BY PROVINCE, 1957 TO 1963

	1957	1958	1959	1960	1961	1962	1963
Newfoundland	13,330	13,683	13,336	15,263	14,886	14,622	15,386
Prince Edward Island	10,064	10,610	11,975	13,005	13,612	15,965	16,669
Nova Scotia	10,090	12,927	14,858	16,113	16,099	15,910	15,760
New Brunswick	10,149	12,618	12,566	15,861	16,700	16,881	18,184
Quebec	10,524	10,954	13,135	12,688	14,292	16,925	16,549
Ontario	13,702	14,748	15,334	16,528	17,501	18,145	21,227
Manitoba	12,970	13,479	14,649	15,199	15,004	15,836	17,150
Saskatchewan	13,886	14,465	14,961	15,806	15,727	14,461	21,436
Alberta	13,410	14,751	15,819	17,648	17,823	18,527	19,105
British Columbia	14,390	14,947	16,436	17,216	17,536	17,182	17,349
Canada	12,641	13,523	14,899	15,477	16,316	17,275	18,799

(a) Professional gross fee income less expenses of practice, plus incidental salaries and wages; these data are completely revised and supersede material published in earlier editions.

(b) Taxable physicians and surgeons only.

The figure was $21,436. The second highest figure for 1963 was in Ontario, at $21,227. Lowest net incomes were reported in Newfoundland, at $15,386, Nova Scotia, at $15,760, Quebec, at $16,549, and Prince Edward Island, at $16,669.

Section 4 - Numbers of Privately Practising Physicians in Canada

There were 21,011 active civilian physicians in Canada in 1962 according to a survey conducted by the Department of National Health and Welfare, giving a ratio of 881 persons per physician for Canada as a whole. Table 28 gives the provincial distribution of the 1962 data and shows also the historical trends for Canada. The ratio of 748 persons per physician for British Columbia in 1962 is the most favourable level of physician-supply yet achieved by a Canadian province. For Canada as a whole, the 1962 level of 881 persons per physician continues the post-war trend of improvement of overall physician supply.

TABLE 28 - ACTIVE CIVILIAN PHYSICIANS AND POPULATION PER PHYSICIAN, CANADA AND PROVINCES, 1962, AND CANADA, SELECTED YEARS, 1901-62

Province	Active civilian physicians, 1962		Year	Active civilian physicians	
	Number	Population per physician		Number	Population per physician
Newfoundland	304	1,539	Census data:		
Prince Edward Is.	87	1,218	1901	5,475	972
Nova Scotia	735	1,012	1911	7,411	970
New Brunswick	458	1,321	1921	8,706	1,008
Quebec	5,932	902	1931	10,020	1,034
Ontario	7,826	808	1941	10,723	1,072
Manitoba	1,085	859	Register of		
Saskatchewan	919	1,010	Physicians,		
Alberta	1,367	998	DNH&W:		
British Columbia	2,210	748	1951	14,163	989
Yukon & N.W.T.	25	1,560	1954	15,651	977
			1959	19,300	900
Canada	21,011(a)	881	1962	21,011	881

(a) Includes 63 not allocated by province.

From Table 29 it is seen that the physicians of Canada are more highly concentrated in the larger centres of population than is the population generally, and that this concentration has been increasing for both the total population and physicians. In addition, the percentage increase of the 1962 total of physicians in centres of less than 10,000 population over that for 1951 was less (5.8) than the percentage increase over 1951 of the 1959 total in these areas (11.9), indicating a decrease in the total number of physicians in these areas during the 1959-62 period. Even though the trends indicated in these data are slightly exaggerated by changes between Censuses in the make-up of census metropolitan areas, it is clear that the overall trend is toward widening of the traditional disparity in availability of physician services between smaller localities and large urban centres.

TABLE 29 - PER CENT OF POPULATION AND OF ACTIVE CIVILIAN PHYSICIANS IN CENTRES OF A) 10,000 POPULATION OR OVER, AND B) LESS THAN 10,000 POPULATION, SHOWING PER CENT INCREASE OF POPULATION AND PHYSICIANS OVER 1951.

Item	Per cent of total			Per cent increase over 1951		
	In centres of:		Total	For centres of:		Total
	10,000 or more(a) population	Less than 10,000 population		10,000 or more(a) population	Less than 10,000 population	
Population:						
1961	57.7	42.3	100.0	55.9	6.3	30.2
1951	48.2	51.8	100.0	..	..	..
Physicians:						
1962	81.0	19.0	100.0	64.6	5.8	48.8
1959	78.2	21.8	100.0	46.8	11.9	37.4
1954	73.7	26.3	100.0	12.3	9.3	11.5
1951	73.2	26.8	100.0	..	..	..

(a) Includes all parts of Census metropolitan areas, regardless of size; size of place for 1962 physicians as in 1961 Census; for 1959 as in 1956 Census; for 1954 and 1951 as in 1951 Census.

Table 30 indicates little real change in recent years in the proportion of active civilian physicians who are engaged primarily in private practice, but an increased emphasis on specialization is indicated within both the private practice and "other work" groups. The increase between 1959 and 1962 in the proportion of physicians who were "interns, residents, fellows" is in line with the trend toward increased specialization and the longer training period involved.

TABLE 30 - PER CENT DISTRIBUTION OF ACTIVE CIVILIAN PHYSICIANS BY NATURE OF MAJOR WORK IN WHICH ENGAGED, 1962, 1959 AND 1954

Nature of major work	1962 (estimate)	1959 (estimate)	1954
	per cent	per cent	per cent
General private practice[a]	37.7	39.3	43.2
Specialist private practice[a]	35.7	34.7	29.1
Total, private practice[a]	73.4	74.0	72.3
Interns, residents, fellows	9.0	8.3	8.3
Other work: Non-specialist	4.7	5.7	8.5
Specialist	12.9	12.0	10.8
Total[b]	100.0	100.0	100.0

(a) Includes group practice and partnerships.
(b) May not total exactly because of rounding.

Note: Data prior to 1959 did not take into account certifications by the College of Physicians and Surgeons of the Province of Quebec. Although designation as a "specialist" did not depend on the holding of formal specialist qualifications, specialization was nevertheless slightly understated in the data prior to 1959, most particularly in Quebec Province.

PART IV - NATIONAL VOLUNTARY HEALTH AND WELFARE ACTIVITIES

A number of national voluntary agencies carry on important work in the provision of health and welfare services, medical research, and education. These agencies, some of which are described below, supplement the services of the federal and provincial authorities in many fields, and play a leading role in stimulating public awareness of health and welfare needs and in promoting action to meet them.

The Canadian Welfare Council. - The Council, established in 1920, is a national voluntary association of English-speaking and French-speaking organizations and individual citizens whose aim is the advancement of social welfare in Canada. Member organizations include community funds and councils, other private social agencies, various federal, provincial, and municipal departments, and citizen groups and individuals active in the fields of health, welfare, and recreation. It furnishes authoritative information, technical consultation, and field service in the main areas of social welfare and provides a means of co-operative planning and action by public and private agencies.

The policies and programs of the Council are determined by its members under the leadership of a nationally representative board of governors. Aided by professional staff, the members work together through Divisions of Family and Child Welfare, Public Welfare, Corrections, and Community Funds and Councils, and through special committees on such subjects as education and personnel for the social services, and aging. Services of the Council include public information and research. The Council publishes periodicals entitled Canadian Welfare, Bien-Être Social Canadien, and The Canadian Journal of Corrections, a directory of Canadian welfare services, pamphlets and bulletins.

The Canadian Diabetic Association. - Formed in 1953 with headquarters in Toronto, the Association has 28 branches established in nine provinces and a French-language affiliate, l'Association du Diabète, in Quebec. The aims of the organization are to promote public education regarding diabetes and the early detection of cases, to teach diabetics self-care, and to conduct research, for example, the Family Tree Research Program. The branches support various services such as free diet counselling and summer camps for diabetic children and adults, and hold 'model schools' or institutes from time to time in many cities.

The Canadian Red Cross Society. - Established in 1896 in Canada, the Society is affiliated with the International Red

Cross and has branches in all ten provinces with national headquarters in Toronto. Its objectives, defined in its Charter, are "... in time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world". Red Cross Society activities are very broad, ranging from national and international disaster relief services to the support of local projects. Its largest single activity in Canada is the operation of the national, free blood transfusion service that keeps hospitals supplied with blood provided by voluntary donors. The Society also conducts important health services including hospital and nursing outposts, homemakers service, sickroom supply loan service, and instruction in water safety and home nursing. The Junior Red Cross promotes health education through its schoolroom branches across Canada; it supports a special fund to supply treatment to needy handicapped children in Canada and a fund to promote understanding among school children of different countries.

The Canadian Rehabilitation Council for the Disabled.- This national agency situated in Toronto was formed in 1962 by the merger of the Canadian Council for Crippled Children with the Canadian Foundation for Poliomyelitis and Rehabilitation. To further its object of co-ordinating activities in all areas for the rehabilitation of the disabled, the Council works with other voluntary agencies concerned with specific disease groups or services. It also carries out such functions as consultative services, public education, and research in this field. In some provinces, these two organizations have also merged to provide treatment, training, and other patient services to disabled persons not reached by existing agencies. In other provinces, the handicapped-children's societies administer case-finding, restorative, and related services including parent counselling, camping, and recreation; such programs are financed by Easter Seal campaigns. The foundations for the disabled in these provinces, financed by the March of Dimes or community chests, provide similar services to disabled adults with more emphasis upon vocational rehabilitation.

The Victorian Order of Nurses.- Since its inception in 1897, the Victorian Order of Nurses has provided a professional home nursing and health counselling service to patients with any type of illness and regardless of their financial status. In all provinces except Prince Edward Island, the association's nurses carry out, under medical direction, bedside nursing, with emphasis upon chronic conditions, and prenatal, postnatal, and newborn care. In some provinces they also assist provincial health authorities in tuberculosis and venereal disease programs and conduct child-health clinics. Through some 120 branches, VON services are available to over one-third of Canada's population. The national office is in Ottawa.

The Canadian National Institute for the Blind.- Since 1918 the Canadian National Institute for the Blind has been the only national agency providing a complete social welfare service to the blind and prevention services to the visually impaired. The national office, located in Toronto, supports eight regional divisions covering all provinces and 50 local branches serving 24,700 registered blind persons and over 100,000 prevention cases in 1962-63. Through its Eye Service, free to those in need of assistance, the Institute arranges for eye examinations and pays for medical treatment, glasses, and visual aids; it also supports the operation of several Low Vision Aid Clinics and Eye Banks in the main cities. Vocational, recreation, and educational services for the blind are provided at 20 residential and service centres located across the country. Home teachers visit the newly blinded of all ages including pre-school-age children to teach them independence in daily living and other skills such as Braille, typing, and handicrafts. Placement officers furnish vocational counselling and arrange for training and employment. Where possible the blind are placed in jobs in general industry, in CNIB canteens, or in farming and small businesses; others are employed in the Institute's sheltered workshops. The National Library circulates Braille magazines and books and recordings and supplies a transcription service to students.

The Health League of Canada.- The Health League of Canada, first established in 1918 as the National Committee for Combating Venereal Disease, now supports a wide variety of public health education activities to prevent disease and raise health standards. The League co-operates with health departments and other national health organizations in disseminating health information. Its technical divisions are concerned with various aspects of public health such as immunization, child and maternal health, fluoridation of water, industrial health, nutrition, gerontology, and other fields. In co-operation with its affiliates, the League administers its program from the national office in Toronto; certain branch activities for the province of Quebec are conducted through its Montreal and Quebec offices. Educational efforts include the provision of speakers for meetings, the preparation of radio scripts, health education films, and the publication of the magazine Health and various bulletins. The League sponsors National Health Week and National Immunization Week.

The St. John Ambulance Association.- The Order of the Hospital of St. John of Jerusalem began as a local unit in Montreal in 1884 and was incorporated on a national basis in 1910 with headquarters in Ottawa. The organization, which has established nine Provincial Councils, is composed of two parts -- the St. John Ambulance Association and the St. John Ambulance Brigade. The Association teaches first aid,

home nursing, and artificial respiration, and is used extensively by Civil Defence, Armed Forces, workmen's compensation, and industrial personnel, while the Brigade directs an emergency corps of trained personnel. Provincial and local units operate training courses, first aid posts, ambulance services, and other activities such as ski patrols. The Association has also organized seven Special Centres for training purposes in several federal government agencies and private industries.

The Canadian Tuberculosis Association.- Founded in 1900 to increase treatment facilities for tuberculosis patients, the Association's objective is the control and ultimate eradication of tuberculosis. Recently, it has also extended its interest to other thoracic diseases. The national office in Ottawa and the provincial and local branches in each province co-operate with the public health agencies in promoting adequate facilities for prevention, diagnosis, treatment, and rehabilitation. The provincial associations assist in case-finding by means of mass X-ray and tuberculin-testing surveys of specific areas and higher risk groups, and carry out extensive health education work; some associations also participate in follow-up and rehabilitation of patients. Publication of educational materials and periodicals, organization of the annual Christmas Seal campaign, and research are centred in the national office. It also makes its consultant services available to federal and provincial health departments.

The National Cancer Institute of Canada.- The National Cancer Institute, composed of persons representing professional societies and agencies concerned with cancer research and therapy, was founded in 1947 to develop a nationally co-ordinated research and professional education program. The Institute supports cancer research projects at universities, hospitals, and its own research units, maintains the Canadian Tumour Registry, provides research fellowships, and, in co-operation with the Canadian Medical Association and medical schools, promotes the post-graduate training of radiation physicists and professional education on cancer topics. It also provides an important statistical service by assisting treatment centres in designing clinical trials and developing standard data on cancer problems. The Institute receives financial support from federal-provincial grants and from the Canadian Cancer Society.

The Canadian Hearing Society.- Organized in 1940 as the National Society of the Deaf and the Hard of Hearing, the Society has offices in Toronto, Ottawa, and London. It is concerned with the preservation of hearing, the treatment of deafness, and the provision of rehabilitation services for those with impaired hearing, including war veterans and children. It provides hearing examinations, counselling,

vocational guidance, and job placement services for the deaf or hard-of-hearing, and hearing aids to indigent persons. It also works closely with the two Ontario Schools for the Deaf. The Society publishes The Hearing Eye and distributes educational material on request.

The Canadian Mental Health Association.- Since its organization in 1918 as the National Committee for Mental Hygiene, the Association has promoted mental health and the best possible care of the mentally ill. Its program of public education, professional and lay training, services to the mentally ill, consultative services, and research is carried out by the national office in Toronto, and its provincial divisions and community branches. To develop public understanding of mental health principles, the Association sponsors discussion groups and prepares a variety of educational materials for the press, radio, and television and for professional personnel. Services to mental patients have grown rapidly as branches have established information and referral centres, volunteer hospital visiting programs, White Cross social centres, foster-home care, and other personal services for patients and their families. Through various studies of mental health problems and the National Mental Health Research Fund, set up in 1957, the Association has stimulated new approaches to prevention and treatment in this field.

The Canadian Arthritis and Rheumatism Society.- This group was formed in 1948 to help persons suffering from the rheumatic diseases by a program of treatment, research, and education. Through its national office in Toronto, eight provincial divisions, and local branches in most towns, the Society has assisted many hospitals to establish arthritis clinics and several to set up rheumatic disease in-patient units, and it provides a home physiotherapy service in the larger cities covering about one-half of the population. Five of the divisions provide mobile consultation services to patients and doctors in rural areas. In 1962, over 13,500 patients benefited from treatment or consultative services from the Society's professional staff of over 100, mostly physiotherapists. The Society also supports clinical and epidemiological research projects and sponsors the regular Canadian Conference on Research in Rheumatic Diseases. Other activities include public educational services stressing early diagnosis and treatment, and the professional training of arthritis specialists.

The Canadian Cancer Society.- Organized in 1938 to coordinate voluntary activities and disseminate knowledge in the cancer field, the Canadian Cancer Society operates in all provinces and has its national office in Toronto. Its chief services are a public education program, welfare services

such as transportation, home nursing, and dressings to cancer patients, and the promotion of medical research through support of research facilities and fellowships for advanced study. Voluntary subscriptions to the Society provide about 80 per cent of the funds for the Research Units of the National Cancer Institute of Canada. The Society also sponsors clinical research projects in other institutions.

The Canadian Heart Foundation.- The Canadian Heart Foundation was formed in 1947 by physicians to co-ordinate research and disseminate information. Its membership consists of lay and medical individuals and organizations interested in promoting cardiovascular research and in both public and professional education. The Foundation makes available grants-in-aid to support various medical research projects and fellowship awards to promising scientists in co-operation with the medical schools and teaching hospitals. Its projects are financed by voluntary donations to the Canadian Heart Fund as well as by federal and provincial grants. The Foundation has established provincial foundations covering all provinces and a national office in Toronto.

The Canadian Paraplegic Association.- The Association was formed in 1945 by a group of paraplegic veterans to ensure provision of adequate treatment and rehabilitation facilities for all persons suffering paralysis caused by disease or injury. Through its national office in Toronto and seven divisional and local offices, the Association's rehabilitation program makes available physical restoration, counselling, and vocational services, prosthetic appliances, and personal aids and other activities to promote the social well-being of paraplegics. A comprehensive service is provided at Lyndhurst Lodge Retraining Centre in Toronto, owned by the Association; elsewhere it arranges for these services with various hospitals and other rehabilitation agencies.

The Multiple Sclerosis Society of Canada.- The Society has been organized since 1948 to support research in multiple sclerosis and allied diseases and to educate the public on the social problem of multiple sclerosis. Its 29 local chapters located in eight provinces raise funds mainly for research but they also provide welfare services to patients in need of wheel chairs and other personal aids. Grants for its medical research projects and fellowships are administered from the national office in Montreal. Local chapters have undertaken patient registries.

The Canadian Association for Retarded Children.- The Association was incorporated in 1958 to co-ordinate the work of organizations for the mentally retarded, now represented by ten provincial and about 250 local groups.

Membership of the local groups exceeds 14,000, most of whom are parents of mentally retarded children. The Association promotes the establishment of assessment clinics, day-training classes, sheltered workshops and activity centres, summer camps, and recreational programs; it also supports research into the causes of mental deficiency. The Association operates over 530 special classes and 20 sheltered workshops for trainable retarded children and adults. Financial support comes from local fund-raising campaigns, community chests, and, in varying degrees, from provincial education and other departments. The national office is in Toronto.

The Muscular Dystrophy Association of Canada.- This Association was organized in 1954 to stimulate and unify research efforts into the cause, nature, and treatment of muscular dystrophy and related diseases and to promote the establishment of facilities for diagnostic, consultative, and treatment services. Under the direction of a national office in Toronto supported by 33 local chapters, its chief activity is the sponsoring of basic and applied research projects in medical schools and other centres across the country. Other activities include providing appliances and transportation to muscular dystrophy patients and supplying information to the public and professionals.

The Canadian Cystic Fibrosis Foundation.- This recently organized national agency has 19 affiliated chapters located in seven provinces. Its objects are to aid patients with this inherited condition, and to promote research, professional training, and public understanding. Several chapters have established clinics for the diagnosis and treatment of cystic fibrosis among children, and all provide patient services including special drugs and equipment. The Foundation initiated its research program in 1962, and intensified the distribution of educational material to parents and the general public. The national office is in Toronto.

Voluntary Medical Insurance.- About 10,800,000 Canadians, or 56 per cent of the population of Canada, had voluntarily secured some protection against the costs of physicians' services at the end of 1964. Their protection was provided by some 62 nonprofit plans with an enrolment of 6,450,000 and 79 private companies giving coverage to an estimated 5,250,000; overlapping enrolment in the two groups amounted to about 900,000. The 10,800,000 net total was 4,900,000 above the 1955 figure, which represented only 38 per cent of the population.

The nonprofit plans took in about $191,600,000 in premiums and $4,300,000 in other revenue in 1964, paid out $174,000,000 in benefits and $13,500,000 for administration, and were left

with a surplus of approximately $8,400,000. Thus, for every dollar of premiums, 91 cents were paid out in benefits, which amounted to approximately $29.67 per person covered. In 1955, benefit payments had been $41,400,000, representing 89 cents of the premium dollar and amounting to only $13.17 per person.

Profit-making private companies wrote $119,700,000 of premiums for health protection in 1964. They paid out $92,000,000 in claims.

Health and welfare services
in Canada